

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G668	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/01/2013
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NAME OF PROVIDER OR SUPPLIER PEAK COMMUNITY SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 324 W MAIN ST WINAMAC, IN 46996
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W000000	<p>This visit was for an extended annual recertification and state licensure survey (Client Protections and Healthcare Services).</p> <p>Dates of Survey: 10/16, 10/17, 10/18, 10/29/13 and 11/1/13</p> <p>Facility Number: 008302 Provider Number: 15G668 AIMS Number: 100235310</p> <p>Surveyor: Amber Bloss, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 11/15/13 by Chris Greeney, QIDP and Ruth Shackelford, QIDP.</p>	W000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W000111	<p>483.410(c)(1) CLIENT RECORDS</p> <p>The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights.</p> <p>Based on observation, record review and interview, the facility failed for 3 of 3 sampled clients (clients #1, #2, and #3), to develop/maintain a record keeping system to document medical information in the clients' records.</p> <p>Findings include:</p> <p>1. On 10/17/13 at 12:37 PM, record review indicated Client #1's diagnoses included, but were not limited to, mild developmental disabilities, chronic paranoid schizophrenia, hypothyroidism, COPD (Chronic Obstructive Pulmonary Disease), hypertension, disease of mitral valve, and seizures.</p> <p>Record review indicated Client #1 had a nursing quarterly review dated 6/29/13 in which the nurse indicated "very concerned with [Client #1]'s gait. He depends on the walls to keep him up on his feet. I was told by staff that this was a good day also. I believe he needs to be evaluated by his PCP (primary care physician) and we need an order for a wheelchair at home and at workshop. Staff would need to walk him when able, but we need the wheelchair for back up to keep client safe." Record review indicated Client #1's nursing quarterly dated 6/29/13 was the most recent nursing quarterly review in Client #1's record.</p> <p>During an interview on 11/1/13 at 1:45 PM, facility nurse indicated she completed Client #1's</p>	W000111	<p>W111 – Client Records Peak Community Services through the IDT will ensure that the facility has developed and maintained a record keeping system that documents the client's health care, active treatment, social information, and protection of the client's rights. Client's 1, 2, and 3 Nursing 09.30.13 quarterly reviews are in the files and available to staff for review as required by regulation.</p> <p>Systematically the QDPPs will inspect client files to ensure that other clients are not affected by this situation. Monitoring and verification to ensure this situation does not reoccur will be done by the Director of Support and Quality Assurance. The Director will verify that the Nursing assessments are in the files as required during the time frame of 12.01.13 to 05.01.14 for clients in the Main Street SGL Residence. The Peak Community Services SGL system's other five homes will be monitored by the QDDP assigned to that home during the time frame of 12.01.13 to 05.31.14 Persons Responsible: Sandra Beckett, QDDP Connie English, Director of Quality and Support</p>	12/01/2013	

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	<p>current quarterly on 9/30/13. The facility nurse indicated she was uncertain why the current nurses quarterly wasn't available in Client #1's record.</p> <p>2. On 10/17/13 at 1:23 PM, record review indicated Client #2's diagnoses included, but were not limited to, moderate intellectual disabilities, psychosis, anxiety, hypertension, and dysthymic disorder (chronic depression). Record review indicated the last documented nurses quarterly was dated 6/29/13.</p> <p>During an interview on 11/1/13 at 1:45 PM, facility nurse indicated she completed Client #2's current quarterly on 9/30/13. The facility nurse indicated she was uncertain why the current nurses quarterly wasn't available in Client #2's record.</p> <p>3. On 10/17/13 at 2:11 PM, record review indicated Client #3's diagnoses included, but were not limited to, severe intellectual disabilities, Type 2 diabetes, osteoporosis, and hypercholesterolemia. Record review indicated the last documented nurses quarterly to be dated 6/29/13.</p> <p>During an interview on 11/1/13 at 1:45 PM, the facility nurse indicated she completed Client #3's current quarterly assessment on 9/15/13. The facility nurse indicated she was uncertain why the current nurses quarterly wasn't available in Client #3's record.</p> <p>9-3-1(a)</p>				

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W000122	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met.</p> <p>Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Client Protections for 1 of 3 sampled clients (Client #1). The facility neglected to implement its written policies and procedures to prevent neglect of Client #1 in regard to falls as the client had a history of falls. The facility neglected to thoroughly investigate potential neglect. The facility neglected to complete a neglect investigation timely. The facility neglected to address the client's health/medical needs in regards to mobility supports when the client's needs changed. The facility neglected to implement, update and/or include specific risk plans which addressed safe strategies for Client #1 to conduct activities of daily living such assisting in the kitchen in regards to his oxygen tubing. The facility failed to take sufficient corrective measures to prevent recurrence of falls and to ensure the safety of Client #1. The facility failed to obtain an wheelchair assessment based on client need. The facility neglected to distinguish between intentional and unintentional falls in Client #1's Behavior Support Plan.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. The facility neglected to implement its written policies and procedures to prevent neglect of the Client #1 in regards to falls. Please see W149. 2. The facility neglected to thoroughly investigate potential neglect for Client #1. Please see W154. 3. The facility neglected to complete a neglect investigation of Client #1 in regard to fall with 	W000122	<p>W 122 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Peak Community Services through the IDT will ensure that written policies and procedures are implemented and monitored for implementation as written. Client # 1's fall plan has been revised to include the use of the mobile oxygen system in the home to ensure that he has access to all rooms and can conduct activities of daily living in the least restrictive manner possible. An assessment will be conducted to ascertain the need for modification in the Client #1's activities of daily living protocol due to the change on oxygen protocol. Client #1's oxygen tubing system will be used in the bedroom only. The lack of oxygen tubing running through the home will eliminate a fall risk for client #1 and the other clients residing in the home. Client # 1 has been referred by his Primary Care Physician for another Physical Therapy consultation to assess the use of a wheelchair, gait belt, and other adaptive mobility equipment. This appointment was held on 10.23.13 and the referral for a physical therapy evaluation was issued. Client #1's Behavior Support Plan will be reviewed and</p>	12/01/2013			

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	<p>injury within 5 working days of the incident. Please see W156.</p> <p>4. The facility failed to take sufficient corrective measures to prevent recurrence of falls and to ensure the safety of Client #1. Please see W157.</p> <p>5. The facility neglected to assess the needs for mobility supports necessary for Client #1 who had a history of falls which increased Client #1's risk for falls. Please see W218.</p> <p>6. The facility neglected to include specific risk plans which addressed safe strategies for Client #1 to conduct activities of daily living such as assisting in the kitchen in regards to his oxygen tubing and neglected to distinguish between intentional and unintentional falls in the Client #1's Behavior Support Plan which increased Client #1's risk for falls. Please see W240.</p> <p>9-3-2(a)</p>		<p>revised to attempt to distinguish between intentional falls by client #1 and accidental falls caused by outside agents. Staff at the Main Street SGL residence will be made aware of the revisions of the plan via in-service training.</p> <p>Systemic changes: A protocol is revised that states that a fall will automatically trigger a review of the fall plan through the IDT to determine the effectiveness of the fall plan to prevent the type of fall that occurred. This procedure will be facilitated by the QDDP. A fall assessment will be completed by the staff person witnessing the fall and this document will be used by the IDT to assess the fall plan for changes to be made if necessary. The program nurse is to receive a copy of the fall assessment as part of her role in the IDT so that they can provide medical expertise in this area. A protocol is revised that states a fall that requires more than routine first aid requires contact with the program nurse who will be requested to make contact with the client to assess the care continuum. The staff requesting the contact should document the contact with the nurse and the nurse should document the client contact in nursing notes that are then made available to the Residential Coordinator and the QDDP. A fall protocol is revised that states that three falls within a 30 day calendar period will automatically require a referral for</p>				

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			a physical therapy assessment be requested from the individual's primary care physician with the client's or legal representative's approval. Monitoring: The monitoring of #1 and # 3 systemic changes will be by the Director of Support and Quality Assurance and the Director of Residential Services via the BDDS Incident Reporting Review Committee. Both Directors receive the Incident Reports as they are processed daily. The Directors will look at the reports for falls by same individual and if there are three within a 30 day period will contact the appropriate residential coordinator and QDDP to ascertain the physical therapy assessment process. This monitoring will be ongoing. Monitoring: The monitoring of #2 systemic change will be by the Residential Manager who receives the Incident Reports on a daily basis. She will coordinate with the Residential Coordinator the contacting of the program nurse to ensure the carrying out of the protocol as required. This monitoring will be ongoing. Systemic changes: The Peak Community Services investigation form has been revised to state that all investigations must be initiated and completed within five calendar days of the reporting of the incident. Peak Community Services SGL coordinator and		

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			Residential Manager will be in-serviced on this requirement through the use of on-line training. This systemic change will be monitored on an on-going basis by the Director of Support and Quality Assurance. Investigation Training has been requested from Steve Corya, Indiana State Department of Health. This training was held 12.10.13. This training will assist Peak Community Services staff on how to conduct a thorough investigation of allegations of abuse, neglect, and mistreatment of clients residing in the six SGL residences of Peak Community Services. Once this training is completed with Mr. Corya other appropriate staff will be trained on the completion of thorough investigations of allegations of abuse, neglect, and mistreatment of clients of Peak Community Services. Amanda Clapp, Residential CoordinatorJan Adair Residential ManagerRick Phelps, Director of Residential ServicesSandra Beckett, QDDPConnie English, Director of Quality and Support		

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W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Based on observation, record review and interview for 1 of 3 sampled clients (#1), the facility neglected to implement its written policies and procedures to prevent neglect of the client in regard to falls.</p> <p>Findings include:</p> <p>On 10/16/13 at 2:39 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports, and internal Incident/Accident (I/A) Reports from 10/16/12 to 10/16/13 were reviewed. The facility's BDDS reports and I/A reports indicated the following:</p> <p>-10/18/12 report indicated at 8:30 AM, Client #1 was "sitting on the toilet when he leaned forward and slid off the front of the toilet." The report indicated Client #1 "hit the right side of his head on the wall and his right arm, and side of abdomen on the floor."</p> <p>-10/18/12 report indicated at 10:10 AM, Client #1 "was being assisted walking and lowered himself to the ground."</p> <p>-10/24/12 report indicated at 1:15 PM, Client #1 fell while standing up from his wheelchair in day program. No marks or injuries noted at the time.</p> <p>-11/30/12 report indicated Client #1 had an urination accident and staff had assist Client #1 in changing when Client #1 stated he had to "pee again." Staff reported when they "turned to get gait belt, [Client #1] got up and peed on the floor</p>	W000149	W 149 - STAFF TREATMENT OF CLIENTS Peak Community Services through the IDT will ensure that written policies and procedures that prohibit mistreatment, neglect and abuse of clients are implemented and monitored for implementation as written. Client # 1's fall plan has been revised to include the use of the mobile oxygen system in the home to ensure that he has access to all rooms and can conduct activities of daily living in the least restrictive manner possible. An assessment will be conducted to ascertain the need for modification in the Client #1's activities of daily living protocol due to the change on oxygen protocol. Client #1's oxygen tubing system will be used in the bedroom only. The lack of oxygen tubing running through the home will eliminate a fall risk for client #1 and the other clients residing in the home. Client # 1 has been referred by his Primary Care Physician for another Physical Therapy consultation to assess the use of a wheelchair, gait belt, and other adaptive mobility equipment. This appointment was held on 10.23.13 and the referral for a physical therapy evaluation was issued. Client #1's Behavior Support Plan will be reviewed and	12/01/2013			

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	<p>then slipped and fell on wet floor." No injuries were noted.</p> <p>-12/3/12 report indicated Client #1 "got up out of wheelchair and fell" at day services. The report indicated Client #1 was "getting up out of wheelchair to get a puzzle piece." Report indicated no bruising noted.</p> <p>-12/6/12 report indicated Client #1 fell while "going to sit down in wheelchair but fell onto (buttocks)."</p> <p>-1/10/13 report indicated Client #1 fell "while walking to the car."</p> <p>-2/5/13 report indicated "staff came into his bedroom, he was on his hands and knees."</p> <p>-3/21/13 report indicated Client #1 "fell off the right side of the toilet" with no injuries noted.</p> <p>-4/30/13 report indicated staff "noticed a bruise on his left side and both eyes" when assisting him with showering. The report indicated "staff member stated that after dinner the previous night [Client #1] was putting his dishes away and she heard a noise and found him on the floor on his knees. Staff assessed him for injuries and saw no injuries at that time." The report indicated Client #1 was evaluated at the emergency room and had experienced a nasal fracture.</p> <p>-6/10/13 report indicated Client #1 "was attempting to get out of bed when he reached forward and fell to the floor." The report indicated staff assessed Client #1 for injuries and noted "a red area to his right are/elbow. No first aid treatment was required - it did not break the skin."</p>		<p>revised to attempt to distinguish between intentional falls by client #1 and accidental falls caused by outside agents. Staff at the Main Street SGL residence will be made aware of the revisions of the plan via in-service training.</p> <p>Systemic changes: A protocol is revised that states that a fall will automatically trigger a review of the fall plan through the IDT to determine the effectiveness of the fall plan to prevent the type of fall that occurred. This procedure will be facilitated by the QDDP. A fall assessment will be completed by the staff person witnessing the fall and this document will be used by the IDT to assess the fall plan for changes to be made if necessary. The program nurse is to receive a copy of the fall assessment as part of her role in the IDT so that they can provide medical expertise in this area. A protocol is revised that states a fall that requires more than routine first aid requires contact with the program nurse who will be requested to make contact with the client to assess the care continuum. The staff requesting the contact should document the contact with the nurse and the nurse should document the client contact in nursing notes that are then made available to the Residential Coordinator and the QDDP. A fall protocol is revised that states that three falls within a 30 day calendar period will automatically require a referral for</p>				

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	<p>-6/14/13 report indicated at 8:30 AM, Client #1 "fell in the living room and dining room." The report indicated Client #1 had "scraped knees, redness on his left side of his face and head."</p> <p>-10/8/13 report indicated Client #1 "got up out of his locked wheelchair without asking staff to assist him as he turned to walk towards staff he lost his balance and fell." The report indicated staff noted "a small red area on his back." The report indicated Client #1 removed his gait belt prior to the fall.</p> <p>On 10/16/13 between 4:20 PM and 6:57 PM, group home observations were conducted. At 4:20 PM, Client #6 was observed sleeping in a reclining chair with continual oxygen and the tubing ran from the oxygen condenser in his bedroom, down the hallway along the floor, and into the living room to Client #6's reclining chair which was situated near the picture window by the front door. At 4:28 PM, Client #1 sat in the living room and DSP (Direct Support Professional) #4 assisted Client #1 with his oxygen tubing by stretching it from his oxygen condenser to him while he was seated opposite Client #6 in the living room. Client #1 did not have a gait belt on. At 4:49 PM, Client #2 left the living room stepping over both Client #1 and Client #6's oxygen tubes. At 5:22 PM, Client #1 stood up from the couch and walked independently with his oxygen tubing from the living room to the dining room. Client #1 picked up his oxygen tubing to walk back to the living room and sit back down. At 5:42 PM, Client #1 walked independently from the living room to the threshold of the kitchen. DSP #4 came behind Client #1 to check his oxygen tubing on the floor to be sure it was not in his way. Client #1 walked into the kitchen independently and sat at the dining room table. At 5:51 PM, Client #1 walked with an unsteady gait</p>		<p>a physical therapy assessment be requested from the individual's primary care physician with the client's or legal representative's approval. Monitoring: The monitoring of #1 and # 3 systemic changes will be by the Director of Support and Quality Assurance and the Director of Residential Services via the BDDS Incident Reporting Review Committee. Both Directors receive the Incident Reports as they are processed daily. The Directors will look at the reports for falls by same individual and if there are three within a 30 day period will contact the appropriate residential coordinator and QDDP to ascertain the physical therapy assessment process. This monitoring will be ongoing. Monitoring: The monitoring of #2 systemic change will be by the Residential Manager who receives the Incident Reports on a daily basis. She will coordinate with the Residential Coordinator the contacting of the program nurse to ensure the carrying out of the protocol as required. This monitoring will be ongoing. Systemic Changes: The Peak Community Services investigation form has been revised to state that all investigations must be initiated and completed within five calendar days of the reporting of the incident. Peak Community Services SGL coordinator and</p>				

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	<p>to wash his hands for dinner with his oxygen tubing on the floor trailing behind him. At 6:03 PM, Client #1 walked back into the living room with an unsteady gait while DSP #4 assisted him with his oxygen tubing. At 6:44 PM, Client #1 was finished with his dinner and stood up from the table. DSP #4 assisted Client #1 by putting his dishes in the sink for him because Client #1's oxygen tubing did not stretch far enough to reach the sink.</p> <p>On 10/17/13 between 7:00 AM and 8:43 AM, group home observations were conducted. At 7:38 AM, Client #1 ate breakfast wearing his gait belt and using his continual oxygen tank wearing the tubing which was stretched from the oxygen condenser in his bedroom. At 7:56 AM, Client #1 got up from the dining room table and stepped on his oxygen tubing. Staff removed Client #1's oxygen tubing as it wasn't long enough to stretch into the kitchen or medication room.</p> <p>On 10/17/13 between 1:42 PM and 2:38 PM, day service observations were conducted. At 1:42 PM, Client #1 was sitting in wheelchair wearing a gait belt. During an interview at 1:49 PM, DSP #2 indicated Client #1 should be seated in his wheelchair at all times at day program because he is a fall risk. DSP #2 stated Client #1 should be wearing his gait belt at all times "unless he takes it off." DSP #2 indicated Client #1 was able to walk on his own with staff assistance with the gait belt. DSP #2 indicated Client #1 will get up during a behavior so staff need to stay nearby in case he falls. DSP #2 indicated the wheelchair Client #1 was using was not a personalized wheelchair but was a transport chair. DSP #2 indicated Client #1 used the transport chair because it was the only wheelchair there that had a seat belt. DSP #2 stated Client #1's wheelchair brakes were locked because "we don't want him to get up and fall."</p>		<p>Residential Manager will be in-serviced on this requirement through the use of on-line training. This systemic change will be monitored on an on-going basis by the Director of Support and Quality Assurance. Investigation Training has been requested from Steve Corya, Indiana State Department of Health. This training is was held 12.10.13. This training will assist Peak Community Services staff on how to conduct a thorough investigation of allegations of abuse, neglect, and mistreatment of clients residing in the six SGL residences of Peak Community Services. Once this training is completed with Mr. Corya other appropriate staff will be trained on the completion of thorough investigations of allegations of abuse, neglect, and mistreatment of clients of Peak Community Services. Persons Responsible: Amanda Clapp, Residential CoordinatorJan Adair Residential ManagerRick Phelps, Director of Residential ServicesSandra Beckett, QDDPCConnie English, Director of Quality and Support</p>				

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	<p>DSP #2 indicated Client #1 was able to lift his own foot rests and knew how to unlock his wheelchair brake. DSP #2 indicated Client #1 did not know how to self ambulate in the wheelchair.</p> <p>On 10/17/13 at 12:37 PM, record review indicated Client #1's diagnoses included, but were not limited to, mild developmental disabilities, chronic paranoid schizophrenia, hypothyroidism, COPD (Chronic Obstructive Pulmonary Disease), hypertension, disease of mitral valve, and seizures. Client #1's ISP (Individual Support Plan) dated 12/17/12 indicated Client #1 had a COPD Management Plan dated 12/13/12 which indicated Client #1's has an order for continual use of oxygen.</p> <p>Nurse's notes indicated an entry dated 4/30/13 which indicated at 8:20 AM "staff realized after [Client #1] got out of shower that he had a black eye. Looked closer and he had 2 black eyes and a crooked nose." The entry indicated there was no paperwork done "so she called night staff from previous day. Client fell into dishwasher. Advised them to take to ER (emergency room) for eval (evaluation) since PCP was out for the day." The nurse's note indicated Client #1's "nose is fractured, not totally broke (sic). Follow-up in 4 days c (with) PCP. Will check on client in 24-48 hr. (hours)." The nurse's note dated on 5/2/13 indicated no "answer when call to check on client" and no "returned call with message left."</p> <p>Client #1's ISP also indicated a risk plan for Rhabdomyolysis (breakdown of muscle fibers that leads to the release of muscle fiber contents into the bloodstream). Client #1's Rhabdomyolysis risk plan indicated the symptoms included, but were not limited to, general weakness, muscle stiffness or aching, muscle tenderness, and weakness of the affected muscles.</p>			

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	<p>Client #1's ISP indicated a "Protocol for Wheelchair" updated on 12/13/12. The protocol indicated Client #1 "has COPD. He enjoys going out in the community, however, if there is going to be a lot of walking, [Client #1] should sit in a wheelchair. If he feels up to walking, he can push the chair and use the chair when he tries." The protocol indicated Client #1 "walks using short strides. Staff need to take their time time when walking with [Client #1]..."</p> <p>Client #1's ISP indicated a "Fall Risk Management Plan" dated 12/13/12 (updated 5/01/13) indicated "Plan & Strategies To Address Identified Risk of Falling" which included the following:</p> <ul style="list-style-type: none"> - Client #1 will be offered a shower chair when in the shower. - Staff will offer physical assistance. - Staff will offer the wheelchair if Client #1 remains unsteady, or if he refuses physical assistance. - Staff will use wheelchair for long distances. - Transport chair to be used at day services. - Gait belt will be used during ambulation. <p>Record review indicated Client #1 had a BSP (Behavior Support Plan) dated 1/11/13 with the target behaviors of aggression, inappropriate assertion, property destruction, and false medical complaints/reports. Client #1's BSP defined "false medical complaints/reports" as "falling to the ground or acting as if he cannot walk when he was walking fine prior to the incident or begins walking fine after the incident or the demand is removed." The BSP indicated "this behavior usually occurs weekly with mild intensity. [Client #1] does not usually receive injury from the behavior." The BSP indicated if Client #1 "states he cannot walk or begins walking slowly as if he</p>						

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	<p>cannot walk well when he was just walking fine and a demand has been placed upon him (chore, activity at day program that he does not enjoy), let him know that he was doing a good job walking or participating before." The BSP indicated "if [Client #1] drops to the ground or sits down on the floor, evaluate and make sure he has no injuries." The BSP indicated when staff "are checking [Client #1] for injuries, do not engage in conversation topics about anything else (favorite movies, things of interest, etc.)." The BSP indicated if Client #1 has an injury, staff should seek medical attention. The BSP indicated if Client #1 "has no injury, and it is obvious that he has only sat down on the floor, let him know that you are continuing on with the activity that was going on prior to this and you would really like him to join you." The BSP indicated "if [Client #1] gets up or begins walking again, provide him with verbal praise letting him know you are proud of him and he is doing a good job."</p> <p>Record review indicated the Behavior Review Committee (BRC) reviewed Client #1 falling two times in their meeting dated 9/11/12. The BRC reviewed Client #1 falling one time in their meeting dated 5/14/13. Both BRC notes indicated no changes to Client #1's BSP. The notes indicated "staff will continue to follow behavior plan as written."</p> <p>Record review indicated Client #1 had a physician order dated 12/21/09 for Client #1 for a wheelchair due to "repeated falling" and "unsteady gait." Record review indicated Client #1 had a physician order dated 11/01/12 for "gait belt x 2 (2 person assist)" due to "unsteady gait" and "increased falling." Record review indicated Client #1 had a change of physician order dated 9/4/13 for "gait belt to be used prn (as needed)." Record review indicated Client #1 had an physical</p>			

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	<p>therapy (PT) assessment dated 10/17/12 which indicated Client #1 was referred due to increasing "falling and unsteady gait. Caregiver indicates that pt (patient) often will fall 2x/day (2 times a day) or more but can have as few as 2 falls a week." The PT assessment indicated Client #1's falls "most of the time will be caught by pt (patient) and performed slowly. Caregiver notices less balance and endurance with ambulation." The PT assessment indicated Client #1 "continued to need high encouragement to perform activities and VCing (verbal cueing), tactile cues for safety. PT (patient) is not safe with amb (ambulation) I (independently). Fatigue occurs quickly and gait pattern is unsafe as well as transfers."</p> <p>Record review indicated Client #1 had a nursing quarterly review dated 6/29/13 in which the nurse indicated "very concerned with [Client #1]'s gait. He depends on the walls to keep him up on his feet. I was told by staff that this was a good day also. I believe he needs to be evaluated by his PCP (primary care physician) and we need an order for a wheelchair at home and at workshop. Staff would need to walk him when able, but we need the wheelchair for back up to keep client safe."</p> <p>An interview with the QDDP (Qualified Development Disabilities Professional) on 10/17/13 at 3:17 PM indicated Client #1 is on continuous oxygen. The QDDP indicated Client #1's oxygen condenser is in his bedroom and the tubing stretches throughout Client #1's home. The QDDP indicated she could see how the oxygen tubing could present an addition fall risk for Client #1 and indicated Client #1's fall risk plan did not address the oxygen tubing. In the residential setting, the QDDP indicated Client #1 should be offered staff assistance when walking but Client #1 can ambulate independently as he would like.</p>				

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	<p>The QDDP stated the level of supervision staff should provide to Client #1 when ambulating in the home is not specified in his fall risk plan other than "staff will offer physical assistance." The QDDP indicated Client #1's BSP (Behavior Support Plan) does not clarify the difference between intentional and unintentional falls. The QDDP indicated the nurses notes did not indicate she physically assessed Client #1 after falls with injury. The QDDP indicated the last revision on Client #1's fall risk plan was on 5/13 and no further IDT meetings have occurred to address Client #1's falls.</p> <p>The facility policy on "Client Rights" (undated) provided by the QDDP as current was reviewed on 11/1/13 at 12:39 PM and indicated "As a participant in Peak Community Services, each client has a right to the following: 1. To be free from harm, including physical, verbal abuse, neglect, or exploitation...".</p> <p>9-3-2(a)</p>			

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W000154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on interview and record review, the facility failed to thoroughly investigate potential neglect for 1 of 3 sampled clients (Client #1) for one of one neglect investigation.</p> <p>Findings include:</p> <p>On 10/16/13 at 2:39 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports, and internal Incident/Accident (I/A) Reports from 10/16/12 to 10/16/13 were reviewed. A BDDS report dated 4/30/13 indicated staff "noticed a bruise on his left side and both eyes" when assisting him with showering. The report indicated "staff member stated that after dinner the previous night [Client #1] was putting his dishes away and she heard a noise and found him on the floor on his knees. Staff assessed him for injuries and saw no injuries at that time."</p> <p>During record review on 10/17/13 at 12:37 PM, a nurse's notes indicated an entry dated 4/30/13 which indicated at 8:20 AM "staff realized after [Client #1] got out of shower that he had a black eye. Looked closer and he had 2 black eyes and a crooked nose." The entry indicated there was no paperwork done "so she called night staff from previous day. Client fell into dishwasher. Advised them to take to ER (emergency room) for eval (evaluation) since PCP (primary care physician) was out for the day." The nurse's note indicated Client #1's "nose is fractured , not totally broke (sic). Follow-up in 4 days c (with) PCP. Will check on client in 24-48 hr. (hours)." The nurse's note dated on 5/2/13 indicated no "answer when</p>	W000154	<p>W 154 - STAFF TREATMENT OF CLIENTS Peak Community Services through the IDT system will ensure that investigations will include evidence that all alleged violations are thoroughly investigated. These investigations will include whether or not there is potential client neglect. Systemic Changes: Peak Community Services Abuse / Neglect / Exploitation / Mistreatment of an Individual / Violation of an Individual's Rights: Reporting/Investigations procedure has been modified to state that the results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. (SGL Manual Page 35/36) Systemic Changes: The Peak Community Services investigation form has been revised to state that all investigations must be initiated and completed within five calendar days of the reporting of the incident. Other changes may be made to the form based on results of the Investigation training offered by Steve Corya, Indiana State Department of Health. This training is scheduled for 12.10.13. Peak Community</p>	12/01/2013			

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	<p>call to check on client" and no "returned call with message left."</p> <p>An "Investigation Report" with an investigation date of 4/30/13 indicated "on 4/30/13 staff noticed bruises on both of [Client #1]'s eyes and left side. Staff asked him what happened. [Client #1] stated he fell. Supervisor contacted staff from prior shift and obtained fall information." The investigation indicated DSP #6 was interviewed. The report indicated DSP #6 "reported that [Client #1] was taking his dishes to the dishwasher. She walked into the office and was standing in the doorway. She heard a crash and turned to look and [Client #1] was on his face and hands bent over the dishwasher." The investigative report indicated DSP #4 was interviewed and indicated he "reported that he was in the living room and heard a crash. He went into the kitchen to assist [DSP #6] in checking for injuries." The report indicated no further information and no recommendations were made. The report failed to indicate whether Client #1 was wearing his oxygen tubing and whether the oxygen tubing could reach as far as the kitchen sink. The investigative report failed to indicate whether Client #1 could safely ambulate independently carrying dishes and whether he was wearing his gait belt. The investigative report failed to indicate whether staff followed Client #1's fall risk plan. The investigative report failed to indicate whether the night shift should have called the nurse to report the fall or further document the fall and an assessment for injuries.</p> <p>On 10/29/13 at 1:33 PM, the Director of Residential Services (DRS) was interviewed and indicated the 4/29/13 incident regarding Client #1's fall with injury was reported to BDDS by the QDDP. The DRS indicated the Residential Coordinator (RC) investigated the fall. The DRS indicated the facility protocol in the investigation</p>		<p>Services SGL coordinators and Residential Manager will be in-serviced on this requirement through the use of on-line training. Investigation Training has been requested from Steve Corya, Indiana State Department of Health. This training is was held 12.10.13. This training will assist Peak Community Services staff on how to conduct a thorough investigation of allegations of abuse, neglect, and mistreatment of clients residing in the six SGL residences of Peak Community Services. Once this training is completed with Mr. Corya other appropriate Peak Community Services staff will be trained on the completion of thorough investigations of allegations of abuse, neglect, and mistreatment of clients of Peak Community Services. Monitoring: This systemic change will be monitored on an on-going basis by the Director of Support and Quality Assurance 12.01.13 to 11.30.14 Persons Responsible: Amanda Clapp, Residential Coordinator Jan Adair Residential Manager Rick Phelps, Director of Residential Services Sandra Beckett, QDDP Connie English, Director of Quality and Support</p>				

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	<p>report is forwarded to the Director of Quality Assurance (DQA) and checked for thoroughness. The DRS indicated the DQA returned the investigation report to the investigator if she feels the investigation in not thorough. The DRS stated Client #1's fall with injury on 4/29/13 was not investigated as potential neglect because "it didn't appear neglectful." The DRS indicated the IDT (Interdisciplinary Team) reviews if fall risk plans were followed during a separation occasion and was unable to indicate whether the IDT met in regards to Client #1's fall which resulted in a fractured nose on 4/29/13. The DRS indicated Client #1 has had an increasing number of falls but some were due to behavior. The DRS indicated the back of the investigation report is signed by the RC and dated on 6/14/13 because the QA sent the report back as requiring more information. The DRS indicated the investigation report on Client #1's fall on 4/30/13 did not indicate whether staff were following Client #1's fall risk plan, whether Client #1 should have been attempting to carry his dishes independently to the sink, whether Client #1 had his oxygen tubing on when he fell and whether the oxygen tubing could reach as far as the sink. The DRS indicated the investigation of the fall on 4/30/13 did not appear thorough.</p> <p>9-3-2(a)</p>						

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W000156	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.</p> <p>Based on record review and interview, the facility failed to complete a neglect investigation in regard to fall with injury within five working days of the incident for 1 of 1 investigation for potential neglect (Client #1).</p> <p>Findings include:</p> <p>On 10/16/13 at 2:39 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports, and internal Incident/Accident (I/A) Reports from 10/16/12 to 10/16/13 were reviewed. A BDDS report dated 4/30/13 indicated staff "noticed a bruise on his left side and both eyes" when assisting him with showering. The report indicated "staff member stated that after dinner the previous night [Client #1] was putting his dishes away and she heard a noise and found him on the floor on his knees. Staff assessed him for injuries and saw no injuries at that time."</p> <p>During record review on 10/17/13 at 12:37 PM, a nurse's notes indicated an entry dated 4/30/13 which indicated at 8:20 AM "staff realized after [Client #1] got out of shower that he had a black eye. Looked closer and he had 2 black eyes and a crooked nose." The entry indicated there was no paperwork done "so she called night staff from previous day. Client fell into dishwasher. Advised them to take to ER (emergency room) for eval (evaluation) since PCP (primary care physician) was out for the day." The nurse's note indicated Client #1's "nose is fractured , not totally broke</p>	W000156	W 156 - STAFF TREATMENT OF CLIENTS Peak Community Services through the IDT and administrative structure ensures that the results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Systemic Changes: Peak Community Services Abuse / Neglect / Exploitation / Mistreatment of an Individual / Violation of an Individual's Rights: Reporting/Investigations procedure has been modified to state that the results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. (SGL Manual Page 35/36) Systemic Changes: The Peak Community Services investigation form has been revised to state that all investigations must be initiated and completed within five calendar days of the reporting of the incident. Peak Community Services SGL coordinator and Residential Manager will be in-serviced on this requirement	12/01/2013			

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	<p>(sic). Follow-up in 4 days c (with) PCP. Will check on client in 24-48 hr. (hours)." The nurse's note dated on 5/2/13 indicated no "answer when call to check on client" and no "returned call with message left."</p> <p>An "Investigation Report" with an investigation date of 4/30/13 indicated "on 4/30/13 staff noticed bruises on both of [Client #1]'s eyes and left side. Staff asked him what happened. [Client #1] stated he fell. Supervisor contacted staff from prior shift and obtained fall information." The investigation indicated DSP #6 was interviewed. The report indicated DSP #6 "reported that [Client #1] was taking his dishes to the dishwasher. She walked into the office and was standing in the doorway. She heard a crash and turned to look and [Client #1] was on his face and hands bent over the dishwasher." The investigative report indicated DSP #4 was interviewed and indicated he "reported that he was in the living room and heard a crash. He went into the kitchen to assist [DSP #6] in checking for injuries." The report indicated no further information and no recommendations were made.</p> <p>On 10/29/13 at 1:33 PM, the Director of Residential Services (DRS) was interviewed and indicated the 4/29/13 incident regarding Client #1's fall with injury was reported to BDDS by the QDDP. The DRS indicated the Residential Coordinator (RC) investigated the fall. The DRS indicated the facility protocol in the investigation report is forwarded to the Director of Quality Assurance (DQA) and checked for thoroughness. The DRS indicated the back of the investigation report is signed by the RC and dated on 6/14/13 because the QA sent the report back as requiring more information. The DRS indicated the final investigation report should have been completed more timely and indicated he was uncertain how</p>		<p>through the use of on-line training.. The Director of Support and Quality Assurance will track the investigations to ensure that the implementation and results are within a five day period in accordance with State Law. Investigation Training has been requested from Steve Corya, Indiana State Department of Health. This training was held 12.10.13. This training will assist Peak Community Services staff on how to conduct a thorough investigation of allegations of abuse, neglect, and mistreatment of clients residing in the six SGL residences of Peak Community Services. Once this training is completed with Mr. Corya other appropriate staff will be trained on the completion of thorough investigations of allegations of abuse, neglect, and mistreatment of clients of Peak Community Services. Monitoring: This systemic change will be monitored on an on-going basis by the Director of Support and Quality Assurance 12.01.13 to 11.30.14 Persons Responsible: Amanda Clapp, Residential Coordinator Jan Adair Residential Manager Rick Phelps, Director of Residential Services Sandra Beckett, QDDP Connie English, Director of Quality and Support</p>				

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	often the QA was updated on the findings during the investigation. 9-3-2(a)				

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W000157	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>Based on observation, interview, and record review, the facility failed to take sufficient corrective measures to prevent recurrence of falls and to ensure the safety of 1 of 3 sampled clients (#1).</p> <p>Findings include:</p> <p>On 10/16/13 at 2:39 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports, and internal Incident/Accident (I/A) Reports from 10/16/12 to 10/16/13 were reviewed. The facility's BDDS reports and I/A reports indicated the following:</p> <p>-10/18/12 report indicated at 8:30 AM, Client #1 was "sitting on the toilet when he leaned forward and slid off the front of the toilet." The report indicated Client #1 "hit the right side of his head on the wall and his right arm, and side of abdomen on the floor."</p> <p>-10/18/12 report indicated at 10:10 AM, Client #1 "was being assisted walking and lowered himself to the ground."</p> <p>-10/24/12 report indicated at 1:15 PM, Client #1 fell while standing up from his</p>	W000157	W 157 - STAFF TREATMENT OF CLIENTS Peak Community Services through the IDT system will ensure that if an alleged violation is verified, appropriate correction action is taken. Client # 1's fall plan has been revised to include the use of the mobile oxygen system in the home to ensure that he has access to all rooms and can conduct activities of daily living in the least restrictive manner possible. An assessment will be conducted to ascertain the need for modification in the Client #1's activities of daily living protocol due to the change on oxygen protocol. Client #1's oxygen tubing system will be used in the bedroom only. The lack of oxygen tubing running through the home will eliminate a fall risk for client #1 and the other clients residing in the home. Client # 1 has been referred by his Primary Care Physician for another Physical Therapy consultation to assess the use of a wheelchair, gait belt, and other adaptive mobility equipment. This PCP appointment was held on 10.23.13 and the referral for a physical therapy evaluation was issued. Client #1's Behavior Support Plan will be reviewed and revised to attempt to distinguish between intentional falls by client	12/01/2013			

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	<p>wheelchair in day program. No marks or injuries noted at the time.</p> <p>-11/30/12 report indicated Client #1 had an urination accident and staff had assist Client #1 in changing when Client #1 stated he had to "pee again." Staff reported when they "turned to get gait belt, [Client #1] got up and peed on the floor then slipped and fell on wet floor." No injuries were noted.</p> <p>-12/3/12 report indicated Client #1 "got up out of wheelchair and fell" at day services. The report indicated Client #1 was "getting up out of wheelchair to get a puzzle piece." Report indicated no bruising noted.</p> <p>-12/6/12 report indicated Client #1 fell while "going to sit down in wheelchair but fell onto (buttocks)."</p> <p>-1/10/13 report indicated Client #1 fell "while walking to the car."</p> <p>-2/5/13 report indicated "staff came into his bedroom, he was on his hands and knees."</p> <p>-3/21/13 report indicated Client #1 "fell off the right side of the toilet" with no injuries noted.</p>		<p>#1 and accidental falls caused by outside agents. Staff at the Main Street SGL residence will be made aware of the revisions of the plan via in-service training.</p> <p>Systemic changes: A protocol is revised that states that a fall will automatically trigger a review of the fall plan through the IDT to determine the effectiveness of the fall plan to prevent the type of fall that occurred. This procedure will be facilitated by the QDDP. A fall assessment will be completed by the staff person witnessing the fall and this document will be used by the IDT to assess the fall plan for changes to be made if necessary. The program nurse is to receive a copy of the fall assessment as part of her role in the IDT so that they can provide medical expertise in this area. A protocol is revised that states that a fall that requires more than routine first aid requires contact with the program nurse who will be requested to make contact with the client to assess the care continuum. The staff requesting the contact should document the contact with the nurse and the nurse should document the client contact in nursing notes that are then made available to the Residential Coordinator and the QDDP. A fall protocol is revised that states that three falls within a 30 day calendar period will automatically require a referral for a physical therapy assessment be requested from the individual's</p>		

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	<p>-4/30/13 report indicated staff "noticed a bruise on his left side and both eyes" when assisting him with showering. The report indicated "staff member stated that after dinner the previous night [Client #1] was putting his dishes away and she heard a noise and found him on the floor on his knees. Staff assessed him for injuries and saw no injuries at that time." The report indicated Client #1 was evaluated at the emergency room and had experienced a nasal fracture.</p> <p>-6/10/13 report indicated Client #1 "was attempting to get out of bed when he reached forward and fell to the floor." The report indicated staff assessed Client #1 for injuries and noted "a red area to his right are/elbow. No first aid treatment was required - it did not break the skin."</p> <p>-6/14/13 report indicated at 8:30 AM, Client #1 "fell in the living room and dining room." The report indicated Client #1 had "scraped knees, redness on his left side of his face and head."</p> <p>-10/8/13 report indicated Client #1 "got up out of his locked wheelchair without asking staff to assist him as he turned to walk towards staff he lost his balance and fell." The report indicated staff noted "a small red area on his back." The report indicated Client #1 removed his gait belt</p>		<p>primary care physician with the client's or legal representative's approval. Monitoring: The monitoring of #1 and # 3 systemic changes will be by the Director of Support and Quality Assurance and the Director of Residential Services via the BDDS Incident Reporting Review Committee. Both Directors receive the Incident Reports as they are processed daily. The Directors will look at the reports for falls by same individual and if there are three within a 30 day period will contact the appropriate residential coordinator and QDDP to ascertain the physical therapy assessment process. This monitoring will be ongoing. Monitoring: The monitoring of #2 systemic change will be by the Residential Manager who receives the Incident Reports on a daily basis. She will coordinate with the Residential Coordinator the contacting of the program nurse to ensure the carrying out of the protocol as required. This monitoring will be ongoing. Systemic changes: The Peak Community Services investigation form has been revised to state that all investigations must be initiated and completed within five calendar days of the reporting of the incident. Peak Community Services SGL coordinator and Residential Manager will be in-serviced on this requirement</p>		

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	<p>prior to the fall.</p> <p>On 10/16/13 between 4:20 PM and 6:57 PM, group home observations were conducted. At 4:20 PM, Client #6 was observed sleeping in a reclining chair with continual oxygen and the tubing ran from the oxygen condenser in his bedroom, down the hallway along the floor, and into the living room to Client #6's reclining chair which was situated near the picture window by the front door. At 4:28 PM, Client #1 sat in the living room and DSP (Direct Support Professional) #4 assisted Client #1 with his oxygen tubing by stretching it from his oxygen condenser to him while he was seated opposite Client #6 in the living room. Client #1 did not have a gait belt on. At 4:49 PM, Client #2 left the living room stepping over both Client #1 and Client #6's oxygen tubes. At 5:22 PM, Client #1 stood up from the couch and walked independently with his oxygen tubing from the living room to the dining room. Client #1 picked up his oxygen tubing to walk back to the living room and sit back down. At 5:42 PM, Client #1 walked independently from the living room to the threshold of the kitchen. DSP #4 came behind Client #1 to check his oxygen tubing on the floor to be sure it was not in his way. Client #1 walked into the kitchen independently and sat at the</p>		<p>through the use of on-line training. This systemic change will be monitored on an on-going basis by the Director of Support and Quality Assurance. Investigation Training has been requested from Steve Corya, Indiana State Department of Health. This training was held 12.10.13. This training will assist Peak Community Services staff on how to conduct a thorough investigation of allegations of abuse, neglect, and mistreatment of clients residing in the six SGL residences of Peak Community Services. Once this training is completed with Mr. Corya other appropriate staff will be trained on the completion of thorough investigations of allegations of abuse, neglect, and mistreatment of clients of Peak Community Services. Amanda Clapp, Residential Coordinator, Jan Adair Residential Manager, Rick Phelps, Director of Residential Services, Sandra Beckett, QDDP, Connie English, Director of Quality and Support</p>		

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	<p>dining room table. At 5:51 PM, Client #1 walked with an unsteady gait to wash his hands for dinner with his oxygen tubing on the floor trailing behind him. At 6:03 PM, Client #1 walked back into the living room with an unsteady gait while DSP #4 assisted him with his oxygen tubing. At 6:44 PM, Client #1 was finished with his dinner and stood up from the table. DSP #4 assisted Client #1 by putting his dishes in the sink for him because Client #1's oxygen tubing did not stretch far enough to reach the sink.</p> <p>On 10/17/13 between 7:00 AM and 8:43 AM, group home observations were conducted. At 7:38 AM, Client #1 ate breakfast wearing his gait belt and using his continual oxygen tank wearing the tubing which was stretched from the oxygen condenser in his bedroom. At 7:56 AM, Client #1 got up from the dining room table and stepped on his oxygen tubing. Staff removed Client #1's oxygen tubing as it wasn't long enough to stretch into the kitchen or medication room.</p> <p>On 10/17/13 between 1:42 PM and 2:38 PM, day service observations were conducted. At 1:42 PM, Client #1 was sitting in wheelchair wearing a gait belt. During an interview at 1:49 PM, DSP #2 indicated Client #1 should be seated in his</p>			

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	<p>wheelchair at all times at day program because he is a fall risk. DSP #2 indicated Client #1 should be wearing his gait belt at all times "unless he takes it off." DSP #2 indicated Client #1 was able to walk on his own with staff assistance with the gait belt. DSP #2 indicated Client #1 will get up during a behavior so staff need to stay near by in case he falls. DSP #2 indicated the wheelchair Client #1 was using was not a personalized wheelchair but was a transport chair. DSP #2 indicated Client #1 used the transport chair because it was the only wheelchair there that had a seat belt. DSP #2 indicated Client #1's wheelchair brakes were locked because "we don't want him to get up and fall." DSP #2 indicated Client #1 was able to lift his own foot rests and knew how to unlock his wheelchair brake. DSP #1 indicated Client #1 did not know how to self ambulate in the wheelchair.</p> <p>On 10/17/13 at 12:37 PM, record review indicated Client #1's diagnoses included, but were not limited to, mild developmental disabilities, chronic paranoid schizophrenia, hypothyroidism, COPD (Chronic Obstructive Pulmonary Disease), hypertension, disease of mitral valve, and seizures. Client #1's ISP (Individual Support Plan) dated 12/17/12 indicated Client #1 had a COPD</p>				

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	<p>Management Plan dated 12/13/12 which indicated Client #1's had an order for continual use of oxygen.</p> <p>Nurse's notes indicated an entry dated 4/30/13 which indicated at 8:20 AM "staff realized after [Client #1] got out of shower that he had a black eye. Looked closer and he had 2 black eyes and a crooked nose." The entry indicated there was no paperwork done "so she called night staff from previous day. Client fell into dishwasher. Advised them to take to ER (emergency room) for eval (evaluation) since PCP was out for the day." The nurse's note indicated Client #1's "nose is fractured , not totally broke (sic). Follow-up in 4 days c (with) PCP. Will check on client in 24-48 hr. (hours)." The nurse's note dated on 5/2/13 indicated no "answer when call to check on client" and no "returned call with message left." No further follow up was documented.</p> <p>Client #1's ISP indicated a "Protocol for Wheelchair" updated on 12/13/12. The protocol indicated Client #1 "has COPD. He enjoys going out in the community, however, if there is going to be a lot of walking, [Client #1] should sit in a wheelchair. If he feels up to walking, he can push the chair and use the chair when he tries." The protocol indicated Client #1 "walks using short strides. Staff need</p>			

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	<p>to take their time time when walking with [Client #1]...". No updates or revisions to the "Protocol for Wheelchair" was documented.</p> <p>Client #1's ISP indicated a "Fall Risk Management Plan" dated 12/13/12 (updated 5/01/13) indicated "Plan & Strategies To Address Identified Risk of Falling" which included the following:</p> <ul style="list-style-type: none"> - Client #1 will be offered a shower chair when in the shower. - Staff will offer physical assistance. - Staff will offer the wheelchair if Client #1 remains unsteady, or if he refuses physical assistance. - Staff will use wheelchair for long distances. - Transport chair to be used at day services. - Gait belt will be used during ambulation. <p>Record review indicated Client #1 had a BSP (Behavior Support Plan) dated 1/11/13 with the target behaviors of aggression, inappropriate assertion, property destruction, and false medical complaints/reports. Client #1's BSP defined "false medical complaints/reports" as "falling to the ground or acting as if he cannot walk when he was walking fine prior to the</p>						

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	<p>incident or begins walking fine after the incident or the demand is removed." The BSP indicated "this behavior usually occurs weekly with mild intensity. [Client #1] does not usually receive injury from the behavior." The BSP indicated if Client #1 "states he cannot walk or begins walking slowly as if he cannot walk well when he was just walking fine and a demand has been placed upon him (chore, activity at day program that he does not enjoy), let him know that he was doing a good job walking or participating before." The BSP indicated "if [Client #1] drops to the ground or sits down on the floor, evaluate and make sure he has no injuries." The BSP indicated when staff "are checking [Client #1] for injuries, do not engage in conversation topics about anything else (favorite movies, things of interest, etc.)." The BSP indicated if Client #1 has an injury, staff should seek medical attention. The BSP indicated if Client #1 "has no injury, and it is obvious that he has only sat down on the floor, let him know that you are continuing on with the activity that was going on prior to this and you would really like him to join you." The BSP indicated "if [Client #1] gets up or begins walking again, provide him with verbal praise letting him know you are proud of him and he is doing a good job."</p>			

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	<p>Record review indicated the Behavior Review Committee (BRC) reviewed Client #1 falling two times in their meeting dated 9/11/12. The BRC reviewed Client #1 falling one time in their meeting dated 5/14/13. Both BRC notes indicate no changes to Client #1's BSP. The notes indicated "staff will continue to follow behavior plan as written." No further recommendations to prevent falls were documented by the BRC.</p> <p>Record review indicated Client #1 had a nursing quarterly review dated 6/29/13 in which the nurse indicated "very concerned with [Client #1]'s gait. He depends on the walls to keep him up on his feet. I was told by staff that this was a good day also. I believe he needs to be evaluated by his PCP (primary care physician) and we need an order for a wheelchair at home and at workshop. Staff would need to walk him when able, but we need the wheelchair for back up to keep client safe."</p> <p>An interview with the QDDP (Qualified Development Disabilities Professional) on 10/17/13 at 3:17 PM indicated Client #1 is on continuous oxygen. The QDDP indicated Client #1's oxygen condenser is in his bedroom and the tubing stretches throughout Client #1's home. The QDDP</p>			

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	<p>indicated she could see how the oxygen tubing could present an addition fall risk for Client #1 and indicated Client #1's fall risk plan did not address the oxygen tubing. The QDDP indicated the level of supervision staff should provide to Client #1 when ambulating in the home is not specified in his fall risk plan other than "staff will offer physical assistance." The QDDP indicated the last revision on Client #1's fall risk plan was on 5/13 and no further IDT meetings have occurred to address Client #1's falls after each subsequent fall with injury on 6/10/13, 6/14/13, or 10/8/13 .</p> <p>9-3-2(a)</p>			

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W000159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>Based on observation, interview and record review for 1 of 3 sampled clients (Client #1), the facility QDDP (Qualified Development Disabilities Professional) failed to assess the needs for mobility supports necessary for Client #1 who had a history of falls. The facility QDDP failed to include specific risk plans which addressed safe strategies to conduct activities of daily living such as assisting in the kitchen in regards to his oxygen tubing and failed to distinguish between intentional and unintentional falls in the Behavior Support Plan. The facility QDDP failed to provide a copy of client's current ISP (Individual Support Plan) to the facility owned day service program.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. The QDDP failed to coordinate an assessment for the needs of mobility supports necessary for Client #1 who had a history of falls. Please see W218. 2. The QDDP failed to include specific risk plans which addressed safe strategies to conduct activities of daily living such as assisting in the kitchen in regards to his oxygen tubing and failed to distinguish between intentional and unintentional falls in the Behavior Support Plan for Client #1. Please see W240. 3. The QDDP failed to provide a copy of Client #1's current ISP (Individual Support Plan) to facility owned day service program for Client #1. Please see W248. 	W000159	W 159 - QUALIFIED MENTAL RETARDATION PROFESSIONAL Peak Community Services through the IDT will ensure that each client's active treatment program is integrated, coordinated and monitored by a Qualified Mental Retardation Professional. Peak Community Services Winamac Day Program has copies of Client # 1's current ISP and risk plans for falls, seizure management, COPD, Choking, Rhabdomyolysis, Protocol for wheelchair, Gait belt safety, and the use of the nebulizer. Client # 1's fall plan has been revised to include the use of the mobile oxygen system in the home to ensure that he has access to all rooms and can conduct activities of daily living in the least restrictive manner possible. An assessment will be conducted to ascertain the need for modification in the Client #1's activities of daily living protocol due to the change on oxygen protocol. Client #1's oxygen tubing system will be used in the bedroom only. The lack of oxygen tubing running through the home will eliminate a fall risk for client #1 and the other clients residing in the home. Client # 1 has been referred to his Primary Care	12/01/2013	

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	9-3-3(a)		Physician for another Physical Therapy consultation to assess the use of a wheelchair, gait belt, and other adaptive mobility equipment. This PCP appointment was held on 10.23.13 and the referral for a physical therapy evaluation was issued. Client #1's Behavior Support Plan will be reviewed and revised to attempt to distinguish between intentional falls by client #1 and accidental falls caused by outside agents. Staff at the Main Street SGL residence will be made aware of the revisions of the plan via in-service training. Systemic changes: A protocol is revised that states that a fall will automatically trigger a review of the fall plan through the IDT to determine the effectiveness of the fall plan to prevent the type of fall that occurred. This procedure will be facilitated by the QDDP. A fall assessment will be completed by the staff person witnessing the fall and this document will be used by the IDT to assess the fall plan for changes to be made if necessary. The program nurse is to receive a copy of the fall assessment as part of her role in the IDT so that they can provide medical expertise in this area. A protocol is revised that states a fall that requires more than routine first aid requires contact with the program nurse who will be requested to make contact with the client to assess the care continuum. The staff requesting		

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			<p>the contact should document the contact with the nurse and the nurse should document the client contact in nursing notes that are then made available to the Residential Coordinator and the QDDP. A fall protocol is revised that states that three falls within a 30 day calendar period will automatically require a referral for a physical therapy assessment be requested from the individual's primary care physician with the client's or legal representative's approval. Monitoring: The monitoring of #1 and # 3 systemic changes will be by the Director of Support and Quality Assurance and the Director of Residential Services via the BDDS Incident Reporting Review Committee. Both Directors receive the Incident Reports as they are processed daily. The Directors will look at the reports for falls by same individual and if there are three within a 30 day period will contact the appropriate residential coordinator and QDDP to ascertain the physical therapy assessment process. This monitoring will be ongoing. Monitoring: The monitoring of #2 systemic change will be by the Residential Manager who receives the Incident Reports on a daily basis. She will coordinate with the Residential Coordinator the contacting of the program nurse to ensure the carrying out of the protocol as required. This</p>	

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			monitoring will be ongoing. Persons Responsible Amanda Clapp, Residential CoordinatorJan Adair Residential ManagerRick Phelps, Director of Residential ServicesSandra Beckett, QDDPCornie English, Director of Quality and Support	

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W000218	<p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include sensorimotor development. Based on observation, interview and record review for 1 of 3 sampled clients (Client #1), the facility failed to assess the needs for mobility supports necessary for Client #1 who had a history of falls.</p> <p>Findings include:</p> <p>On 10/16/13 at 2:39 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports, and internal Incident/Accident (I/A) Reports from 10/16/12 to 10/16/13 were reviewed. The facility's BDDS reports and I/A reports indicated the following:</p> <p>-10/18/12 report indicated at 8:30 AM, Client #1 was "sitting on the toilet when he leaned forward and slid off the front of the toilet." The report indicated Client #1 "hit the right side of his head on the wall and his right arm, and side of abdomen on the floor."</p> <p>-10/18/12 report indicated at 10:10 AM, Client #1 "was being assisted walking and lowered himself to the ground."</p> <p>-10/24/12 report indicated at 1:15 PM, Client #1 fell while standing up from his wheelchair in day program. No marks or</p>	W000218	218 - INDIVIDUAL PROGRAM PLAN Peak Community Services through the IDT will ensure that the comprehensive functional assessment includes sensorimotor development. Client # 1 has been referred by his Primary Care Physician for another Physical Therapy consultation to assess the use of a wheelchair, gait belt, and other adaptive mobility equipment. This appointment was held on 10.23.13 and the referral for a physical therapy evaluation was issued. The results of this assessment will be incorporated within the overall the comprehensive functional assessment. Client #1 will have an updated comprehensive functional assessment that includes sensorimotor development upon the conclusion of the Physical Therapy evaluation that has been scheduled. Client #1 will have an updated ISP that included information and goals from the updated comprehensive functional assessment that includes sensorimotor development upon the conclusion of the Physical Therapy evaluation that has been scheduled. Client # 1's fall plan has been revised to include the use of the mobile oxygen system	12/01/2013	

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	<p>injuries noted at the time.</p> <p>-11/30/12 report indicated Client #1 had an urination accident and staff had assist Client #1 in changing when Client #1 stated he had to "(urinate) again." Staff reported when they "turned to get gait belt, [Client #1] got up and (urinated) on the floor then slipped and fell on wet floor." No injuries were noted.</p> <p>-12/3/12 report indicated Client #1 "got up out of wheelchair and fell" at day services. The report indicated Client #1 was "getting up out of wheelchair to get a puzzle piece." Report indicated no bruising noted.</p> <p>-12/6/12 report indicated Client #1 fell while "going to sit down in wheelchair but fell onto butt."</p> <p>-1/10/13 report indicated Client #1 fell "while walking to the car."</p> <p>-2/5/13 report indicated "staff came into his bedroom, he was on his hands and knees."</p> <p>-3/21/13 report indicated Client #1 "fell off the right side of the toilet" with no injuries noted.</p> <p>-4/30/13 report indicated staff "noticed a</p>		<p>in the home to ensure that he has access to all rooms and can conduct activities of daily living in the least restrictive manner possible. An assessment will be conducted to ascertain the need for modification in the Client #1's activities of daily living protocol due to the change on oxygen protocol. Client #1's oxygen tubing system will be used in the bedroom only. The lack of oxygen tubing running through the home will eliminate a fall risk for client #1 and the other clients residing in the home. Client #1's Behavior Support Plan will be reviewed and revised to attempt to distinguish between intentional falls by client #1 and accidental falls caused by outside agents. Staff at the Main Street SGL residence will be made aware of the revisions of the plan via in-service training. Systematically Peak Community Services through the QDDP system will review all CFA's of SGL clients to ensure that the comprehensive functional assessment contains sensorimotor development information. Monitoring: The Peak Community Services Residential Manager will monitor annual Individual Support Plan documents for an inclusive comprehensive functional assessment that contains sensorimotor development information. This monitoring will take place for all ISP's written from 12.01.13 to 05.01.14.</p>				

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	bruise on his left side and both eyes" when assisting him with showering. The report indicated "staff member stated that after dinner the previous night [Client #1] was putting his dishes away and she heard a noise and found him on the floor on his knees. Staff assessed him for injuries and saw no injuries at that time." The report indicated Client #1 was evaluated at the emergency room and had experienced a nasal fracture. Nurse's notes indicated an entry dated 4/30/13 which indicated at 8:20 AM "staff realized after [Client #1] got out of shower that he had a black eye. Looked closer and he had 2 black eyes and a crooked nose." The entry indicated there was no paperwork done "so she called night staff from previous day. Client fell into dishwasher. Advised them to take to ER (emergency room) for eval (evaluation) since PCP was out for the day." The nurse's note indicated Client #1's "nose is fractured , not totally broke (sic). Follow-up in 4 days c (with) PCP. Will check on client in 24-48 hr. (hours)." The nurse's note dated on 5/2/13 indicated no "answer when call to check on client" and no "returned call with message left." -6/10/13 report indicated Client #1 "was attempting to get out of bed when he reached forward and fell to the floor." The report indicated staff assessed Client #1 for injuries and noted "a red area to his		Persons Responsible Jan Adair Residential Manager Sandra Beckett, QDDP				

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	<p>right are/elbow. No first aid treatment was required - it did not break the skin."</p> <p>-6/14/13 report indicated at 8:30 AM, Client #1 "fell in the living room and dining room." The report indicated Client #1 had "scraped knees, redness on his left side of his face and head."</p> <p>-10/8/13 report indicated Client #1 "got up out of his locked wheelchair without asking staff to assist him as he turned to walk towards staff he lost his balance and fell." The report indicated staff noted "a small red area on his back." The report indicated Client #1 removed his gait belt prior to the fall.</p> <p>On 10/16/13 between 4:20 PM and 6:57 PM, group home observations were conducted. At 4:20 PM, Client #1 was in the medication room being assisted with a breathing treatment. Client #6 was observed sleeping in a reclining chair in the living room. Client #6 was on continual oxygen and the tubing ran from the oxygen condenser in his bedroom, down the hallway along the floor, and into the living room to Client #6's reclining chair which was situated near the picture window by the front door. At 4:28 PM, Client #1 was done with his breathing treatment. Client #1 sat in the living room and DSP (Direct Support</p>						

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	<p>Professional) #4 assisted Client #1 with his oxygen tubing by stretching it from his oxygen condenser to him while he was seated opposite Client #6 in the living room. Client #1 did not have a gait belt on. Client #2 sat next to Client #6 in another reclining in the living room. At 4:49 PM, Client #2 left the living room stepping over both Client #1 and Client #6's oxygen tubes. After medication pass between 4:54 PM and 5:15 PM, Client #1 and Client #6 returned to the living room with their continual oxygen. At 5:22 PM, Client #1 stands up from the couch and walks independently with his oxygen tubing from the living room to the dining room. Client #1 picked up his oxygen tubing to walk back to the living room and sit back down. At 5:42 PM, Client #1 walked independently from the living room to the threshold of the kitchen. DSP #4 came behind Client #1 to check his oxygen tubing on the floor to be sure it was not in his way. Client #1 walks into the kitchen independently and sat at the dining room table. At 5:51 PM, Client #1 walked with an unsteady gait to wash his hands for dinner with his oxygen tubing on the floor trailing behind him. At 6:03 PM, Client #1 walks back into the into the living room with an unsteady gait while DSP #4 assisted him with his oxygen tubing. Between 6:18 PM and 6:57 PM, the clients ate dinner. At 6:44 PM, Client</p>			

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	<p>#1 was finished with his dinner and stood up from the table. DSP #4 assisted Client #1 by putting his dishes in the sink for him because Client #1's oxygen tubing did not stretch far enough to reach the sink.</p> <p>On 10/17/13 between 7:00 AM and 8:43 AM, group home observations were conducted. At 7:38 AM, Client #1 ate breakfast wearing his gait belt and using his continual oxygen tank wearing the tubing which is stretched from the oxygen condenser in his bedroom. At 7:56 AM, Client #1 gets up from the dining room table and stepped on his oxygen tubing. Staff removed Client #1's oxygen tubing as it isn't long enough to stretch into the kitchen and medication room. DSP #5 assisted Client #1 while he walked into the medication room by holding his gait belt.</p> <p>On 10/17/13 between 1:42 PM and 2:38 PM, day service observations were conducted. At 1:42 PM, Client #1 was sitting in wheelchair wearing a gait belt. At 1:49 PM, Client #1 was still seat in a wheelchair with his feet on the foot rests. During an interview at 1:49 PM, DSP #2 indicated Client #1 should be seated in his wheelchair at all times at day program because he is a fall risk. DSP #2 indicated Client #1 should be wearing his</p>				

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	<p>gait belt at all times "unless he takes it off." DSP #2 indicated Client #1 was able to walk on his own with staff assistance with the gait belt. DSP #2 indicated Client #1 will get up during a behavior so staff need to stay near by in case he falls. DSP #2 indicated the wheelchair Client #1 was using was not a personalized wheelchair but was a transport chair. DSP #2 indicated Client #1 used the transport chair because it was the only wheelchair there that had a seat belt. DSP #2 indicated Client #1's wheelchair brakes were locked because "we don't want him to get up and fall." DSP #2 indicated Client #1 was able to lift his own foot rests and knew how to unlock his wheelchair brake. DSP #1 indicated Client #1 did not know how to self ambulate in the wheelchair so staff push him in the wheelchair to the restroom.</p> <p>On 10/17/13 at 12:37 PM, record review indicated Client #1's diagnoses included, but were not limited to, mild developmental disabilities, chronic paranoid schizophrenia, hypothyroidism, COPD (Chronic Obstructive Pulmonary Disease), hypertension, disease of mitral valve, and seizures. Client #1's ISP (Individual Support Plan) dated 12/17/12 indicated Client #1 had a COPD Management Plan dated 12/13/12 which</p>						

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	<p>indicated Client #1's has an order for continual use of oxygen.</p> <p>Client #1's ISP also indicated a risk plan for Rhabdomyolysis (breakdown of muscle fibers that leads to the release of muscle fiber contents into the bloodstream). Client #1's Rhabdomyolysis risk plan indicated the symptoms included, but were not limited to, general weakness, muscle stiffness or aching, muscle tenderness, and weakness of the affected muscles.</p> <p>Client #1's ISP indicated a "Protocol for Wheelchair" updated on 12/13/12. The protocol indicated Client #1 "has COPD. He enjoys going out in the community, however, if there is going to be a lot of walking, [Client #1] should sit in a wheelchair. If he feels up to walking, he can push the chair and use the chair when he tries." The protocol indicated Client #1 "walks using short strides. Staff need to take their time time when walking with [Client #1]...".</p> <p>Client #1's ISP indicated a "Fall Risk Management Plan" dated 12/13/12 (updated 5/01/13) indicated "Plan & Strategies To Address Identified Risk of Falling" which included the following:</p> <p>- Client #1 will be offered a shower chair</p>						

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	<p>when in the shower.</p> <ul style="list-style-type: none"> - Staff will offer physical assistance. - Staff will offer the wheelchair if Client #1 remains unsteady, or if he refuses physical assistance. - Staff will use wheelchair for long distances. - Transport chair to be used at day services. - Gait belt will be used during ambulation. <p>Record review indicated Client #1 had a physician order dated 12/21/09 for Client #1 for a wheelchair due to "repeated falling" and "unsteady gait." Record review indicated Client #1 had a physician order dated 11/01/12 for "gait belt x 2 (2 person assist)" due to "unsteady gait" and "increased falling." Record review indicated Client #1 had a change of physician order dated 9/4/13 for "gait belt to be used prn (as needed)." Record review indicated Client #1 had an physical therapy (PT) assessment dated 10/17/12 which indicated Client #1 was referred due increasing "falling and unsteady gait. Caregiver indicates that pt (patient) often will fall 2x/day (2 times a day) or more but can have as few as 2 falls a week." The PT assessment indicated Client #1's falls "most of the time will be caught by pt (patient) and performed slowly. Caregiver notices less</p>						

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	<p>balance and endurance with ambulation." The PT assessment indicated Client #1 "continued to need high encouragement to perform activities and VCing (verbal cueing), tactile cues for safety. PT (patient) is not safe with amb (ambulation) I (independently). Fatigue occurs quickly and gait pattern is unsafe as well as transfers." Record review indicated Client #1 was given suggested exercises and had physical therapy appointments on 11/1/12, 11/8/12, 11/13/12, and 11/15/12. Record review indicated Client #1 had no further PT assessment or gait assessment after the falls on 11/30/12, 12/3/12, 12/6/12, 1/10/13, 2/5/13, 3/21/13, 4/30/13, 6/10/13, 6/14/13, and 10/8/13.</p> <p>Record review indicated Client #1 had a nursing quarterly review dated 6/29/13 in which the nurse indicated "very concerned with [Client #1]'s gait. He depends on the walls to keep him up on his feet. I was told by staff that this was a good day also. I believe he needs to be evaluated by his PCP (primary care physician) and we need an order for a wheelchair at home and at workshop. Staff would need to walk him when able, but we need the wheelchair for back up to keep client safe."</p> <p>An interview with the QDDP (Qualified</p>						

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Development Disabilities Professional) on 10/17/13 at 3:17 PM indicated Client #1's gait belt order was changed on 9/4/13 from a gait belt with 2 person assist to PRN (as needed) use because Client #1 "takes the gait belt off a lot." The QDDP indicated Client #1 had not received a wheelchair assessment. The QDDP indicated a transport wheelchair was used in day services and a wheelchair was available to Client #1 in the residential setting. The QDDP indicated there was no follow up on the nurse quarterly dated 6/29/13 recommendations. The QDDP indicated Client #1 had no further doctor appointments after the nurse quarterly to clarify orders for the wheelchair and to assess the safety of his gait or to assess for needed mobility supports.</p> <p>9-3-4(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G668	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/01/2013
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W000240	<p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence.</p> <p>Based on observation, interview and record review for 1 of 3 sampled clients (#1), the facility failed to include specific risk plans which addressed safe strategies to conduct activities of daily living such as assisting in the kitchen in regards to his oxygen tubing and failed to distinguish between intentional and unintentional falls in the Behavior Support Plan.</p> <p>Findings include:</p> <p>1. On 10/16/13 at 2:39 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports and internal Incident/Accident (I/A) Reports from 10/16/12 to 10/16/13 were reviewed. A BDDS report dated 4/30/13 indicated staff "noticed a bruise on his left side and both eyes" when assisting him with showering. The report indicated "staff member stated that after dinner the previous night [Client #1] was putting his dishes away and she heard a noise and found him on the floor on his knees. Staff assessed him for injuries and saw no injuries at that time."</p> <p>During record review on 10/17/13 at 12:37 PM, a nurse's notes indicated an entry dated 4/30/13 which indicated at 8:20 AM "staff realized after [Client #1] got out of shower that he had a black eye. Looked closer and he had 2 black eyes and a crooked nose." The entry indicated there was no paperwork done "so she called night staff from previous day. Client fell into dishwasher. Advised them to take to ER (emergency room) for eval (evaluation) since PCP (primary care physician) was out for the day." The nurse's note indicated</p>	W000240	W 240 - INDIVIDUAL PROGRAM PLAN Peak Community Services through the IDT system will ensure that the individual program plan describes relevant interventions to support the individual toward independence. Client #1 will have an updated Individual Program Plan that includes information and goals from the updated comprehensive functional assessment and includes sensorimotor development upon the conclusion of the Physical Therapy evaluation that has been scheduled. Client # 1 has been referred by his Primary Care Physician for another Physical Therapy consultation to assess the use of a wheelchair, gait belt, and other adaptive mobility equipment. This PCP appointment was held on 10.23.13 and the referral for a physical therapy evaluation was issued. The results of this assessment will be incorporated within the overall the comprehensive functional assessment. Client #1 will have an updated comprehensive functional assessment that includes sensorimotor development upon the conclusion of the Physical Therapy evaluation that has been	12/01/2013			

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	<p>Client #1's "nose is fractured , not totally broke (sic). Follow-up in 4 days c (with) PCP. Will check on client in 24-48 hr. (hours)." The nurse's note dated on 5/2/13 indicated no "answer when call to check on client" and no "returned call with message left."</p> <p>On 10/16/13 between 4:20 PM and 6:57 PM, group home observations were conducted. At 4:20 PM, Client #6 was sleeping in a reclining chair on continual oxygen and the tubing ran from the oxygen condenser in his bedroom, down the hallway along the floor. At 4:28 PM, Client #1 sat in the living room and DSP (Direct Support Professional) #4 assisted Client #1 with his oxygen tubing by stretching it from his oxygen condenser to him while he was seated opposite Client #6 in the living room. Client #1 did not have a gait belt on. At 4:49 PM, Client #2 left the living room stepping over both Client #1 and Client #6's oxygen tubes. At 5:22 PM, Client #1 stood up from the couch and walked independently with his oxygen tubing from the living room to the dining room. Client #1 picked up his oxygen tubing to walk back to the living room and sit back down. At 5:42 PM, Client #1 walked independently from the living room to the threshold of the kitchen. DSP #4 came behind Client #1 to check his oxygen tubing on the floor to be sure it was not in his way. Client #1 walked into the kitchen independently and sat at the dining room table. At 5:51 PM, Client #1 walked with an unsteady gait to wash his hands for dinner with his oxygen tubing on the floor trailing behind him down the hallway bathroom. At 6:03 PM, Client #1 walked back into the into the living room with an unsteady gait while DSP #4 assisted him with his oxygen tubing. At 6:44 PM, Client #1 was finished with his dinner and stood up from the table. DSP #4 assisted Client #1 by putting his dishes in the sink for him because Client #1's</p>		<p>scheduled. Client # 1's fall plan has been revised to include the use of the mobile oxygen system in the home to ensure that he has access to all rooms and can conduct activities of daily living in the least restrictive manner possible. An assessment will be conducted to ascertain the need for modification in the Client #1's activities of daily living protocol due to the change on oxygen protocol. Client #1's oxygen tubing system will be used in the bedroom only. The lack of oxygen tubing running through the home will eliminate a fall risk for client #1 and the other clients residing in the home. Client #1's Behavior Support Plan will be reviewed and revised to attempt to distinguish between intentional falls by client #1 and accidental falls caused by outside agents. Staff at the Main Street SGL residence will be made aware of the revisions of the plan via in-service training. Systematically Peak Community Services through the QDDP system will review all IPP's of Peak Community Services' SGL clients to ensure that the IPP describes relevant interventions to support the individual toward independence. Monitoring: The Peak Community Services Residential Manager will monitor annual Individual Program Plan documents to ensure that the IPP describes relevant interventions to support the individual toward independence. This monitoring</p>				

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	<p>oxygen tubing did not stretch far enough to reach the sink.</p> <p>On 10/17/13 between 7:00 AM and 8:43 AM, group home observations were conducted. At 7:38 AM, Client #1 ate breakfast wearing his gait belt and using his continual oxygen tank wearing the tubing which is stretched from the oxygen condenser in his bedroom. At 7:56 AM, Client #1 gets up from the dining room table and stepped on his oxygen tubing. Staff removed Client #1's oxygen tubing as it isn't long enough to stretch into the kitchen and medication room. DSP #5 assisted Client #1 while he walked into the medication room by holding his gait belt.</p> <p>Record review on 10/17/13 at 12:37 PM indicated Client #1's diagnoses included, but were not limited to, mild developmental disabilities, chronic paranoid schizophrenia, hypothyroidism, COPD (Chronic Obstructive Pulmonary Disease), hypertension, disease of mitral valve, and seizures. Client #1's ISP (Individual Support Plan) dated 12/17/12 indicated Client #1 had a COPD Management Plan dated 12/13/12 which indicated Client #1's has an order for continual use of oxygen.</p> <p>Record review indicated Client #1 had a physician order dated 12/21/09 for Client #1 for a wheelchair due to "repeated falling" and "unsteady gait." Record review indicated Client #1 had a physician order dated 11/01/12 for "gait belt x 2 (2 person assist)" due to "unsteady gait" and "increased falling." Record review indicated Client #1 had a change of physician order dated 9/4/13 for "gait belt to be used prn (as needed)." Record review indicated Client #1 had an physical therapy (PT) assessment dated 10/17/12 which indicated Client #1 was referred due increasing "falling and unsteady gait. Caregiver indicates</p>		<p>will take place for all ISP's written from 12.01.13 to 05.01.14. Persons Responsible Jan Adair Residential Manager Sandra Beckett, QDDP</p>				

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	<p>that pt (patient) often will fall 2x/day (2 times a day) or more but can have as few as 2 falls a week." The PT assessment indicated Client #1's falls "most of the time will be caught by pt (patient) and performed slowly. Caregiver notices less balance and endurance with ambulation." The PT assessment indicated Client #1 "continued to need high encouragement to perform activities and VCing (verbal cueing), tactile cues for safety. PT (patient) is not safe with amb (ambulation) I (independently). Fatigue occurs quickly and gait pattern is unsafe as well as transfers."</p> <p>An interview with the QDDP (Qualified Development Disabilities Professional) on 10/17/13 at 3:17 PM indicated Client #1 is on continuous oxygen. The QDDP indicated Client #1's oxygen condenser is in his bedroom and the tubing stretches throughout Client #1's home. The QDDP indicated she could see how the oxygen tubing could present an addition fall risk for Client #1 and indicated Client #1's fall risk plan did not address the oxygen tubing. The QDDP indicated Client #1's ISP (Individual Support Plan) did not address Client #1 performing activities of daily living, such as meal preparation or doing dishes safely in regards to the length of the oxygen tubing.</p> <p>2. On 10/16/13 at 2:39 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports, and internal Incident/Accident (I/A) Reports from 10/16/12 to 10/16/13 were reviewed. The facility's BDDS reports and I/A reports indicated the following:</p> <p>-8/30/12 at 2:15 PM while at the facility owned Day Services, Client #1 fell while "backing up to try and make a basket with pop can." The "First Aid Report" indicated "no bruising, redness, or</p>						

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	<p>bumps" at the time but "possible bump and bruising but hard to tell due to already having a lot."</p> <p>-9/4/12 report indicated Client #1 fell while at Day Services. The report indicated Client #1 "went to get out of his wheelchair to (sic) lost his balance and fell." The incident report indicated Client #1 was standing up to "give hug to staff." The report indicated "one side of the brakes were not locked at the time." The report indicated Client #1 had a "small abrasion to his back."</p> <p>-9/5/12 report indicated, while in the shower, Client #1 "slid down the wall and landed on his bottom. Staff assessed him for injuries none noted at the time - however by afternoon staff noticed a bruise on his underside of his left forearm and a scratch on the underside of his right forearm which are believed to be caused from his earlier fall."</p> <p>-9/6/12 at 9:50 AM, a fall assessment indicated Client #1 fell in the driveway while standing. The assessment indicated no new injuries were noted.</p> <p>-10/12/12 report indicated Client #1 was having breakfast and "jumped up and out of his wheelchair tripping over the foot pedal and falling to the floor." The report indicated staff noted "scratches on right elbow and bruises to his buttocks."</p> <p>-10/7/12 report indicated Client #1 had "thrown himself on the floor." The report indicated staff noted Client #1 had opened an old scab and it was bleeding.</p> <p>-10/18/12 report indicated at 8:30 AM, Client #1 was "sitting on the toilet when he leaned forward and slid off the front of the toilet." The report indicated Client #1 "hit the right side of his head</p>			

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	<p>on the wall and his right arm, and side of abdomen on the floor."</p> <p>-10/18/12 report indicated at 10:10 AM, Client #1 "was being assisted walking and lowered himself to the ground."</p> <p>-10/24/12 report indicated at 1:15 PM, Client #1 fell while standing up from his wheelchair in day program. No marks or injuries noted at the time.</p> <p>-11/30/12 report indicated Client #1 had an urination accident and staff had assist Client #1 in changing when Client #1 stated he had to "pee again." Staff reported when they "turned to get gait belt, [Client #1] got up and peed on the floor then slipped and fell on wet floor." No injuries were noted.</p> <p>-12/3/12 report indicated Client #1 "got up out of wheelchair and fell" at day services. The report indicated Client #1 was "getting up out of wheelchair to get a puzzle piece." Report indicated no bruising noted.</p> <p>-12/6/12 report indicated Client #1 fell while "going to sit down in wheelchair but fell onto butt."</p> <p>-1/10/13 report indicated Client #1 fell "while walking to the car."</p> <p>-2/5/13 report indicated "staff came into his bedroom, he was on his hands and knees."</p> <p>-3/21/13 report indicated Client #1 "fell off the right side of the toilet" with no injuries noted.</p> <p>-4/30/13 report indicated staff "noticed a bruise on his left side and both eyes" when assisting him with showering. The report indicated "staff</p>				

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	<p>member stated that after dinner the previous night [Client #1] was putting his dishes away and she heard a noise and found him on the floor on his knees. Staff assessed him for injuries and saw no injuries at that time." The report indicated Client #1 was evaluated at the emergency room and had experienced a nasal fracture.</p> <p>-6/10/13 report indicated Client #1 "was attempting to get out of bed when he reached forward and fell to the floor." The report indicated staff assessed Client #1 for injuries and noted "a red area to his right are/elbow. No first aid treatment was required - it did not break the skin."</p> <p>-6/14/13 report indicated at 8:30 AM, Client #1 "fell in the living room and dining room." The report indicated Client #1 had "scraped knees, redness on his left side of his face and head."</p> <p>-10/8/13 report indicated Client #1 "got up out of his locked wheelchair without asking staff to assist him as he turned to walk towards staff he lost his balance and fell." The report indicated staff noted "a small red area on his back." The report indicated Client #1 removed his gait belt prior to the fall.</p> <p>On 10/17/13 at 12:37 PM, record review indicated Client #1's diagnoses included, but were not limited to, mild developmental disabilities, chronic paranoid schizophrenia, hypothyroidism, COPD (Chronic Obstructive Pulmonary Disease), hypertension, disease of mitral valve, and seizures.</p> <p>Record review indicated Client #1 had a BSP (Behavior Support Plan) dated 1/11/13 with the target behaviors of aggression, inappropriate assertion, property destruction, and false medical complaints/reports. Client #1's BSP defined "false</p>						

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	<p>medical complaints/reports" as "falling to the ground or acting as if he cannot walk when he was walking fine prior to the incident or begins walking fine after the incident or the demand is removed." The BSP indicated "this behavior usually occurs weekly with mild intensity. [Client #1] does not usually receive injury from the behavior." The BSP indicated if Client #1 "states he cannot walk or begins walking slowly as if he cannot walk well when he was just walking fine and a demand has been placed upon him (chore, activity at day program that he does not enjoy), let him know that he was doing a good job walking or participating before." The BSP indicated "if [Client #1] drops to the ground or sits down on the floor, evaluate and make sure he has no injuries." The BSP indicated when staff "are checking [Client #1] for injuries, do not engage in conversation topics about anything else (favorite movies, things of interest, etc.)." The BSP indicated if Client #1 has an injury, staff should seek medical attention. The BSP indicated if Client #1 "has no injury, and it is obvious that he has only sat down on the floor, let him know that you are continuing on with the activity that was going on prior to this and you would really like him to join you." The BSP indicated "if [Client #1] gets up or begins walking again, provide him with verbal praise letting him know you are proud of him and he is doing a good job."</p> <p>Record review indicated the Behavior Review Committee (BRC) reviewed Client #1 falling two times in their meeting dated 9/11/12. The BRC reviewed Client #1 falling one time in their meeting dated 5/14/13. Both BRC notes indicate no changes to Client #1's BSP. The notes indicated "staff will continue to follow behavior plan as written."</p> <p>Record review indicated Client #1 had a nursing</p>			
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	<p>quarterly review dated 6/29/13 in which the nurse indicated "very concerned with [Client #1]'s gait. He depends on the walls to keep him up on his feet. I was told by staff that this was a good day also. I believe he needs to be evaluated by his PCP (primary care physician) and we need an order for a wheelchair at home and at workshop. Staff would need to walk him when able, but we need the wheelchair for back up to keep client safe."</p> <p>An interview with the QDDP (Qualified Development Disabilities Professional) on 10/17/13 at 3:17 PM indicated Client #1's BSP (Behavior Support Plan) does not clarify the difference between intentional and unintentional falls. The QDDP indicated Client #1's falls were reviewed by the Behavior Committee but no recommendations were made in regards to reducing the number of falls. The QDDP indicated the last revision on Client #1's fall risk plan was on 5/13 and no further IDT meetings have occurred to address Client #1's falls.</p> <p>On 10/29/13 at 1:33 PM, the Director of Residential Services (DRS) was interviewed and indicated Client #1 has had an increasing number of falls but some were due to behavior. The DRS indicated Client #1's BSP (Behavior Support Plan) should have better clarified the difference between Client #1's intentional and unintentional falls.</p> <p>9-3-4(a)</p>						

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W000248	<p>483.440(c)(7) INDIVIDUAL PROGRAM PLAN</p> <p>A copy of each client's individual plan must be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian.</p> <p>Based on record review and interview, the facility failed to provide a copy of client's current ISP (Individual Support Plan) to the facility owned day service program for 1 of 3 sampled clients. (Client #1)</p> <p>Findings include:</p> <p>On 10/16/13 at 2:39 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports and internal Incident/Accident (I/A) Reports from 10/16/12 to 10/16/13 were reviewed. The facility's BDDS reports and I/A reports indicated the following falls occurred at the facility owned day service program:</p> <p>-10/24/12 report indicated at 1:15 PM, Client #1 fell while standing up from his wheelchair in day program. No marks or injuries noted at the time.</p> <p>-12/3/12 report indicated Client #1 "got up out of wheelchair and fell" at day services. The report indicated Client #1 was "getting up out of wheelchair to get a puzzle piece." Report indicated no bruising noted.</p> <p>-12/6/12 report indicated Client #1 fell while "going to sit down in wheelchair but fell onto butt."</p> <p>-10/8/13 report indicated Client #1 "got up out of his locked wheelchair without asking staff to assist him as he turned to walk towards staff he lost his</p>	W000248	248 - INDIVIDUAL PROGRAM PLAN Peak Community Services through the auspices of the Interdisciplinary Team will ensure that a copy of each client's individual plan is made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian. Peak Community Services Winamac Day Program has copies of Client # 1's current ISP and risk plans for falls, seizure management, COPD, Choking, Rhabdomyolysis, Protocol for wheelchair, Gait belt safety, and the use of the nebulizer. The Peak Community Services Winamac Day Program Manager has been in-serviced on the need for the Day program staff to have current information on client # 1 and all other clients served in the Winamac Day program. The Winamac Day service staff have been in-serviced on the above mentioned risk plans. Systematically this citation will be remediated by going through all Winamac Day Service files to ensure that current information is available to Day program staff as called for by	12/01/2013	

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	<p>balance and fell." The report indicated staff noted "a small red area on his back." The report indicated Client #1 removed his gait belt prior to the fall.</p> <p>On 10/17/13 between 1:42 PM and 2:38 PM, the facility owned day program was observed. At 1:42 PM, Client #1 was sitting in a wheelchair wearing a gait belt. Client #1 had his feet on the foot rests. Throughout the observation, Client #1 remained seated in the transport wheelchair either at the table with craft activities or away from the table listening to music. Throughout the observation, Client #1's feet remained on the foot rests and his wheels were locked.</p> <p>On 10/17/13 at 1:49 PM during an interview with day program DSP (direct support professional) #2, indicated Client #1 remained seated in the wheelchair throughout day program because he was a fall risk. DSP #2 indicated Client #1 wore the gait belt at all times unless he chooses to take it off. DSP #2 indicated Client #1 was able to walk on his own but staff always assisted him using the gait belt. DSP #2 stated Client #1's wheels on his wheelchair were locked because the staff "don't want him to get up and fall." The DSP indicated Client #1 used a transport chair because it was the only one with a seat belt. DSP #2 indicated Client #1 was able to lift up his own foot rests and to unlock his wheels. DSP #2 indicated Client #1 does not know how to self ambulate in the wheelchair so they push his wheelchair to the bathroom when he needs to use to the bathroom.</p> <p>During an interview on 10/17/13 at 2:02 PM, DSP #3 indicated Client #1 sits in the wheelchair during his time in day program. DSP #3 indicated staff encourage him to remain in the wheelchair and push him where he needs to go. DSP #3</p>		<p>regulation. Monitoring will be done by Director of Day Services by reviewing 10% of Winamac Day Service files on a monthly basis from 12.01.13 to 05.30.14. Person Responsible: Sandra Beckett, QDDPKelly Bendel, Winamac Day Services ManagerMelissa Derflinger, Director of Day Services</p>		

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	<p>indicated she did not know where Client #1's fall risk plan was kept.</p> <p>On 10/17/13 at 2:04 PM, the Day Service record review indicated the day service program did not have a current copy of Client #1's fall risk plan. The day service program had a fall risk plan for Client #1 dated 9/6/12. Record review indicated the facility day service program had an outdated ISP (Individual Support Plan) for Client #1 dated 12/19/11. The day service had an outdated Seizure Management Plan for Client #1 dated 11/14/09. The facility owned day service program did not the following plans available to day service program:</p> <p>-COPD (Chronic Obstructive Pulmonary Disease) Management Plan dated 12/13/12.</p> <p>-Choking Prevention Plan dated 12/13/12.</p> <p>-Rhabdomyolysis (breakdown of muscle fibers that leads to the release of muscle fiber contents into the bloodstream) Risk Plan dated 12/13/12.</p> <p>-"Protocol for Wheelchair" dated 12/13/12.</p> <p>-"Gait Belt Safety" protocol (undated).</p> <p>-"Risk Plan for using Nebulizer" dated 12/13/12.</p> <p>Record review indicated the facility owned day program did not have current updated plans for the following:</p> <p>-Seizure Management Plan dated 12/12/12.</p> <p>-"Fall Risk Management Plan" dated 12/13/12 (updated 5/01/13) indicated "Plan & Strategies To Address Identified Risk of Falling" which included the following:</p>				

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	<p>An interview with the QDDP (Qualified Development Disabilities Professional) on 10/17/13 at 3:17 PM indicated the Day Program Manager was responsible for maintaining current ISPs with current client risk plans in the day service program books. The QDDP indicated the facility owned day service program should have had a current ISP for Client #1.</p> <p>9-3-4(a)</p>			

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W000318	<p>483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met.</p> <p>Based on observation, interview, and record review, the facility failed to meet the Condition of Participation: Health Care Services for 1 of 3 sampled clients (Client #1). The facility's nursing services failed to meet the health care needs of the clients it served. The facility's health care services failed to assess, monitor and/or address client's health care needs.</p> <p>Findings include:</p> <p>The facility's health care services failed to ensure the facility's nursing services met the nursing need of the client. The facility's health care services failed to address Client #1's health/medical needs when the client's needs changed. The facility's health care services failed to ensure the client's health/medical needs were assessed, monitored and/or documented. The facility's health care services failed to ensure the nursing services updated and/or included specific risk plans which addressed the client's health/medical needs. Please see W331.</p> <p>9-3-6(a)</p>	W000318	<p>W 318 - HEALTH CARE SERVICES Peak Community Services through the IDT system will ensure that specific health care services requirements are met as required by statute. Client #1 was seen by his Primary Care Physician on October 23,2013. His PCP addressed the incontinence issue and an incontinence management plan was developed with comments from the results of this appointment. Systematically to address this issue Peak Community Services has revised its Nursing Protocols to include the following. Supervised Group Living program nurse will be provided with a draft copy of all medical risk plans for review and comments prior to the implementation of such plans. Supervised Group Living program nurse will be sent all BDDS Incident reports referencing medical issues for review and comment. Supervised Group Living program nurse will be notified of all non-routine medical appointments, the reason for them and the results of them. The Medical visit form should be scanned and e-mailed to the nurse for review and comment. Systemic :A protocol is revised that states that a fall will automatically trigger a review of</p>	12/01/2013			

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			<p>the fall plan through the IDT to determine the effectiveness of the fall plan to prevent the type of fall that occurred. This procedure will be facilitated by the QDDP. A fall assessment will be completed by the staff person witnessing the fall and this document will be used by the IDT to assess the fall plan for changes to be made if necessary. The program nurse is to receive a copy of the fall assessment as part of her role in the IDT so that they can provide medical expertise in this area. A protocol is revised that states that a fall that requires more than routine first aid requires contact with the program nurse who will be requested to make contact with the client to assess the care continuum. The staff requesting the contact should document the contact with the nurse and the nurse should document the client contact in nursing notes that are then made available to the Residential Coordinator and the QDDP. A fall protocol is revised that states that three falls within a 30 day calendar period will automatically require a referral for a physical therapy assessment be requested from the individual's primary care physician with the client's or legal representative's approval. Monitoring: The monitoring of #1 and # 3 systemic changes will be by the Director of Support and Quality Assurance and the Director of Residential Services via the BDDS Incident</p>		

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			Reporting Review Committee. Both Directors receive the Incident Reports as they are processed daily. The Directors will look at the reports for falls by same individual and if there are three within a 30 day period will contact the appropriate residential coordinator and QDDP to ascertain the physical therapy assessment process. This monitoring will be ongoing. Monitoring: The monitoring of #2 systemic change will be by the Residential Manager who receives the Incident Reports on a daily basis. She will coordinate with the Residential Coordinator the contacting of the program nurse to ensure the carrying out of the protocol as required. This monitoring will be ongoing. In addition to the revision of protocols the Director of Residential Services, Residential Manager and The Director of Support and Quality will convene with the Peak Community Services SGL program nurse to assess the need for changes to the current Nursing Quarterly Assessment and the protocol for the completion of them. Peak administrative staff will contact, the Developmental Disabilities Nurses Association (DDNA). DDNA is a 501(c)(3) not-for-profit nursing specialty organization that is committed to advocacy, education, and support for nurses who provide services to persons		

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			with intellectual and developmental disabilities (IDD). Peak Community Services will investigate this organization as to their capability to provide support and education for its SGL program nurse. Peak Community Services will also advertise for additional SGL program nursing personnel to ensure that specific health care services requirements are met as required by statute. Persons Responsible: Persons Responsible: Jan Adair, Residential Manager Sandra Beckett, QDDP Connie English, Director of Support and Quality Rick Phelps, Director of Residential Services Alison Harris, LPN		

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W000331	<p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on interview and record review, the facility nursing staff failed to reassess individuals after falls and update a fall plan based on the result of those assessments for 1 of 3 sampled clients (Client #1). The facility failed to ensure an incontinence management plan was developed and implemented when a need was identified for 1 of 3 sampled clients (Client #1). The facility nursing staff failed to follow through with physician services when a need was identified in regards to gait assessment and mobility supports for Client #1.</p> <p>Findings include:</p> <p>1. On 10/16/13 at 2:39 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports, and internal Incident/Accident (I/A) Reports from 10/16/12 to 10/16/13 were reviewed. The facility's BDDS reports and I/A reports indicated the following:</p> <p>-10/18/12 report indicated at 8:30 AM, Client #1 was "sitting on the toilet when he leaned forward and slid off the front of the toilet." The report indicated Client #1 "hit the right side of his head on the wall and his right arm, and side of abdomen on the floor."</p> <p>-10/18/12 report indicated at 10:10 AM, Client #1 "was being assisted walking and lowered himself to the ground."</p> <p>-10/24/12 report indicated at 1:15 PM, Client #1 fell while standing up from his wheelchair in day program. No marks or injuries noted at the time.</p>	W000331	331 - NURSING SERVICES Peak Community Service through the IDT will ensure the provision of nursing services in accordance with client needs. Client #1 was seen by his Primary Care Physician on October 23, 2013. His PCP addressed the incontinence issue and an incontinence management plan was developed with comments from the results of this appointment. Client # 1's fall plan has been revised to include the use of the mobile oxygen system in the home to ensure that he has access to all rooms and can conduct activities of daily living in the least restrictive manner possible. The program nurse has had input into the revision of the plan. An assessment will be conducted to ascertain the need for modification in the Client #1's activities of daily living protocol due to the change on oxygen protocol. Client #1's oxygen tubing system will be used in the bedroom only. The lack of oxygen tubing running through the home will eliminate a fall risk for client #1 and the other clients residing in the home. Client # 1 has been referred to his Primary Care Physician for another Physical Therapy consultation to assess the use of a wheelchair, gait belt, and other adaptive mobility	12/01/2013			

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	<p>-11/30/12 report indicated Client #1 had an urination accident and staff had assist Client #1 in changing when Client #1 stated he had to "pee again." Staff reported when they "turned to get gait belt, [Client #1] got up and peed on the floor then slipped and fell on wet floor." No injuries were noted.</p> <p>-12/3/12 report indicated Client #1 "got up out of wheelchair and fell" at day services. The report indicated Client #1 was "getting up out of wheelchair to get a puzzle piece." Report indicated no bruising noted.</p> <p>-12/6/12 report indicated Client #1 fell while "going to sit down in wheelchair but fell onto butt."</p> <p>-1/10/13 report indicated Client #1 fell "while walking to the car."</p> <p>-2/5/13 report indicated "staff came into his bedroom, he was on his hands and knees."</p> <p>-3/21/13 report indicated Client #1 "fell off the right side of the toilet" with no injuries noted.</p> <p>-4/30/13 report indicated staff "noticed a bruise on his left side and both eyes" when assisting him with showering. The report indicated "staff member stated that after dinner the previous night [Client #1] was putting his dishes away and she heard a noise and found him on the floor on his knees. Staff assessed him for injuries and saw no injuries at that time." The report indicated Client #1 was evaluated at the emergency room and had experienced a nasal fracture.</p> <p>-6/10/13 report indicated Client #1 "was attempting to get out of bed when he reached</p>		<p>equipment. This appointment was held on 10.23.13 and the referral for a physical therapy evaluation was issued. Client #1's Behavior Support Plan will be reviewed and revised to attempt to distinguish between intentional falls by client #1 and accidental falls caused by outside agents. Staff at the Main Street SGL residence will be made aware of the revisions of the plan via in-service training.</p> <p>Systemic changes: A protocol is revised that states that a fall will automatically trigger a review of the fall plan through the IDT to determine the effectiveness of the fall plan to prevent the type of fall that occurred. This procedure will be facilitated by the QDDP. A fall assessment will be completed by the staff person witnessing the fall and this document will be used by the IDT to assess the fall plan for changes to be made if necessary. The program nurse is to receive a copy of the fall assessment as part of her role in the IDT so that they can provide medical expertise in this area. A protocol is revised that states that a fall with injury requires contact with the program nurse who will be requested to make contact with the client to assess the care continuum. The staff requesting the contact should document the contact with the nurse and the nurse should document the client contact in nursing notes that are then made available to the Residential Coordinator and the</p>				

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	<p>forward and fell to the floor." The report indicated staff assessed Client #1 for injuries and noted "a red area to his right are/elbow. No first aid treatment was required - it did not break the skin."</p> <p>-6/14/13 report indicated at 8:30 AM, Client #1 "fell in the living room and dining room." The report indicated Client #1 had "scraped knees, redness on his left side of his face and head."</p> <p>-10/8/13 report indicated Client #1 "got up out of his locked wheelchair without asking staff to assist him as he turned to walk towards staff he lost his balance and fell." The report indicated staff noted "a small red area on his back." The report indicated Client #1 removed his gait belt prior to the fall.</p> <p>On 10/17/13 at 12:37 PM, record review indicated Client #1's diagnoses included, but were not limited to, mild developmental disabilities, chronic paranoid schizophrenia, hypothyroidism, COPD (Chronic Obstructive Pulmonary Disease), hypertension, disease of mitral valve, and seizures. Client #1's ISP (Individual Support Plan) dated 12/17/12 indicated Client #1 had a "Fall Risk Management Plan" dated 12/13/12 (updated 5/01/13) which indicated "Plan & Strategies To Address Identified Risk of Falling" which included the following:</p> <ul style="list-style-type: none"> - Client #1 will be offered a shower chair when in the shower. - Staff will offer physical assistance. - Staff will offer the wheelchair if Client #1 remains unsteady, or if he refuses physical assistance. - Staff will use wheelchair for long distances. - Transport chair to be used at day services. - Gait belt will be used during ambulation. 		<p>QDDP. A fall protocol is revised that states that three falls within a 30 day calendar period will automatically require a referral for a physical therapy assessment be requested from the individual's primary care physician with the client's or legal representative's approval. Monitoring: The monitoring of #1 and # 3 systemic changes will be by the Director of Support and Quality Assurance and the Director of Residential Services via the BDDS Incident Reporting Review Committee. Both Directors receive the Incident Reports as they are processed daily. The Directors will look at the reports for falls by same individual and if there are three within a 30 day period will contact the appropriate residential coordinator and QDDP to ascertain the physical therapy assessment process. This monitoring will be ongoing. Monitoring: The monitoring of #2 systemic change will be by the Residential Manager who receives the Incident Reports on a daily basis. She will coordinate with the Residential Coordinator the contacting of the program nurse to ensure the carrying out of the protocol as required. This monitoring will be ongoing. Systemically in addition to address this issue Peak Community Services has revised its Nursing Protocols to include the following. Supervised Group</p>				

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	<p>An interview with the QDDP (Qualified Development Disabilities Professional) on 10/17/13 at 3:17 PM indicated Client #1 is on continuous oxygen. The QDDP indicated Client #1's oxygen condenser is in his bedroom and the tubing stretches throughout Client #1's home. The QDDP indicated she could see how the oxygen tubing could present an addition fall risk for Client #1 and indicated Client #1's fall risk plan did not address the oxygen tubing. The QDDP indicated Client #1's gait belt order was changed on 9/4/13 from a gait belt with 2 person assist to PRN (as needed) use because Client #1 takes the gait belt off a lot. The QDDP indicated Client #1's fall risk plan had not been updated to reflect the Client #1's current PRN order for the gait belt. The QDDP stated Client #1 indicated the level of supervision staff should provide to Client #1 when ambulating in the home is not specified in his fall risk plan other than "staff will offer physical assistance." The QDDP indicated the last revision on Client #1's fall risk plan was on 5/13 and no further IDT meetings or fall plan revisions have occurred to address each of Client #1's subsequent falls.</p> <p>Nurse's notes indicated an entry dated 4/30/13 which indicated at 8:20 AM "staff realized after [Client #1] got out of shower that he had a black eye. Looked closer and he had 2 black eyes and a crooked nose." The entry indicated there was no paperwork done "so she called night staff from previous day. Client fell into dishwasher. Advised them to take to ER (emergency room) for eval (evaluation) since PCP was out for the day." The nurse's note indicated Client #1's "nose is fractured , not totally broke (sic). Follow-up in 4 days c (with) PCP. Will check on client in 24-48 hr. (hours)." The nurse's note dated on 5/2/13 indicated no "answer when call to check on client" and no "returned call with message left."</p>		<p>Living program nurse will be provided with a draft copy of all medical risk plans for review and comments prior to the implementation of such plans. Supervised Group Living program nurse will be sent all BDDS Incident reports referencing medical issues for review and comment. Supervised Group Living program nurse and Residential Manager will be notified of all non-routine medical appointments, the reason for them and the results of them via the Peak Community Services Medical Visit form. This form is to be e-mailed to the Residential Manager who will then forward the Peak Community Services medical visit form via e-mail to the nurse for review and comment. Monitoring of the above systemic changes will be by the Residential Manager. They will coordinate with the Residential Coordinator the contacting of the program nurse to ensure the carrying out of the protocol as required. The Residential Manager will contact the SGL program nurse on a weekly basis to ensure that they are receiving the appropriate information from the Residential Coordinators. This monitoring will be ongoing from 12.01.13 to the next survey. In addition to the revision of protocols the Director of Residential Services, Residential Manager and The Director of Support and Quality will convene</p>				

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	<p>During an interview on 11/1/13 at 1:45 PM, the facility nurse indicated staff should inform her of each fall. The nurse indicated the first fall she was notified for Client #1 was the fall resulting in a fracture nose in April 2013. The nurse indicated she was not aware of Client #1's fall on 10/18/13. The nurse indicated she did not physically assess Client #1 after his falls with injury. The nurse stated the protocol is for staff to call her after a fall with injury, if the injury is "bad enough", she will recommend they take him to the emergency room. The nurse indicated she does phone follow ups after hospital discharges and if the client isn't improving, she will go to the residence to physically assess the injury. The nurse indicated she did not physically assess Client #1 after his fall which resulted in a fractured nose. The nurse indicated she did not recommend further revisions to Client #1's fall plan because she was unaware of the number of falls he has had in the last year.</p> <p>2. On 10/16/13 at 2:39 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports, and internal Incident/Accident (I/A) Reports from 10/16/12 to 10/16/13 were reviewed. The facility's BDDS reports and I/A reports indicated the following:</p> <p>-10/26/12 internal report indicated Client #1 "urinated in his jeans at 10:30 AM and again at 1:30 PM. He did not ask to use the restroom before either of his accidents."</p> <p>-11/30/12 report indicated Client #1 had an urination accident and staff had assist Client #1 in changing when Client #1 stated he had to "(urinate) again." Staff reported when they "turned to get gait belt, [Client #1] got up and (urinated) on the floor then slipped and fell on wet floor." No injuries were noted.</p>		<p>with the Peak Community Services SGL program nurse to assess the need for changes to the current Nursing Quarterly Assessment and the protocol for the completion of them. Peak administrative staff will contact, the Developmental Disabilities Nurses Association (DDNA). DDNA is a 501(c)(3) not-for-profit nursing specialty organization that is committed to advocacy, education, and support for nurses who provide services to persons with intellectual and developmental disabilities (IDD). Peak Community Services will investigate this organization as to their capability to provide support and education for its SGL program nurse. Peak Community Services will also advertize for additional SGL program nursing personnel to ensure that specific health care services requirements are met as required by statute. Persons Responsible: Jan Adair, Residential Manager Sandra Beckett, QDDP Connie English, Director of Support and Quality Rick Phelps, Director of Residential Services Amanda Clapp, Residential Coordinator</p>				

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	<p>On 10/17/13 at 12:37 PM, record review indicated Client #1's diagnoses included, but were not limited to, mild developmental disabilities, chronic paranoid schizophrenia, hypothyroidism, COPD (Chronic Obstructive Pulmonary Disease), hypertension, disease of mitral valve, and seizures. Client #1's ISP (Individual Support Plan) dated 12/17/12 indicated Client #1 had no protocol for incontinence management.</p> <p>An interview with the QDDP (Qualified Development Disabilities Professional) on 10/17/13 at 3:17 PM stated Client #1 is not always incontinent but it is a "newer occurrence." The QDDP indicated she was unable to verify whether Client #1 had seen a physician regarding the increasing episodes of incontinence because the notes on the doctor visit form were not detailed. The QDDP indicated the IDT (Interdisciplinary Team) did not consider incontinence in regards to additional risk for falls.</p> <p>During an interview on 11/1/13 at 1:45 PM, the facility nurse stated she is responsible for the client quarterlies which are basic assessments such as "weights and vitals" and she did not assess Client #1 for incontinence. The facility nurse indicated she was unaware Client #1 had episodes of incontinence. The nurse indicated had she known Client #1 had episodes of incontinence, the protocol would have been to refer Client #1 to his primary care physician for further assessment and recommendations.</p> <p>3. On 10/16/13 at 2:39 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports and internal Incident/Accident (I/A) Reports from 10/16/12 to 10/16/13 were reviewed. The facility's BDDS reports and I/A reports indicated the following:</p>				

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	<p>-10/18/12 report indicated at 8:30 AM, Client #1 was "sitting on the toilet when he leaned forward and slid off the front of the toilet." The report indicated Client #1 "hit the right side of his head on the wall and his right arm, and side of abdomen on the floor."</p> <p>-10/18/12 report indicated at 10:10 AM, Client #1 "was being assisted walking and lowered himself to the ground."</p> <p>-10/24/12 report indicated at 1:15 PM, Client #1 fell while standing up from his wheelchair in day program. No marks or injuries noted at the time.</p> <p>-11/30/12 report indicated Client #1 had an urination accident and staff had assist Client #1 in changing when Client #1 stated he had to "(urinate) again." Staff reported when they "turned to get gait belt, [Client #1] got up and (urinated) on the floor then slipped and fell on wet floor." No injuries were noted.</p> <p>-12/3/12 report indicated Client #1 "got up out of wheelchair and fell" at day services. The report indicated Client #1 was "getting up out of wheelchair to get a puzzle piece." Report indicated no bruising noted.</p> <p>-12/6/12 report indicated Client #1 fell while "going to sit down in wheelchair but fell onto (buttocks)."</p> <p>-1/10/13 report indicated Client #1 fell "while walking to the car."</p> <p>-2/5/13 report indicated "staff came into his bedroom, he was on his hands and knees."</p> <p>-3/21/13 report indicated Client #1 "fell off the</p>			

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	<p>right side of the toilet" with no injuries noted.</p> <p>-4/30/13 report indicated staff "noticed a bruise on his left side and both eyes" when assisting him with showering. The report indicated "staff member stated that after dinner the previous night [Client #1] was putting his dishes away and she heard a noise and found him on the floor on his knees. Staff assessed him for injuries and saw no injuries at that time." The report indicated Client #1 was evaluated at the emergency room and had experienced a nasal fracture. Nurse's notes indicated an entry dated 4/30/13 which indicated at 8:20 AM "staff realized after [Client #1] got out of shower that he had a black eye. Looked closer and he had 2 black eyes and a crooked nose." The entry indicated there was no paperwork done "so she called night staff from previous day. Client fell into dishwasher. Advised them to take to ER (emergency room) for eval (evaluation) since PCP was out for the day." The nurse's note indicated Client #1's "nose is fractured , not totally broke. Follow-up in 4 days c (with) PCP. Will check on client in 24-48 hr. (hours)." The nurse's note dated on 5/2/13 indicated no "answer when call to check on client" and no "returned call with message left."</p> <p>-6/10/13 report indicated Client #1 "was attempting to get out of bed when he reached forward and fell to the floor." The report indicated staff assessed Client #1 for injuries and noted "a red area to his right are/elbow. No first aid treatment was required - it did not break the skin."</p> <p>-6/14/13 report indicated at 8:30 AM, Client #1 "fell in the living room and dining room." The report indicated Client #1 had "scraped knees, redness on his left side of his face and head."</p>						

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	<p>-10/8/13 report indicated Client #1 "got up out of his locked wheelchair without asking staff to assist him as he turned to walk towards staff he lost his balance and fell." The report indicated staff noted "a small red area on his back." The report indicated Client #1 removed his gait belt prior to the fall.</p> <p>On 10/17/13 at 12:37 PM, record review indicated Client #1's diagnoses included, but were not limited to, mild developmental disabilities, chronic paranoid schizophrenia, hypothyroidism, COPD (Chronic Obstructive Pulmonary Disease), hypertension, disease of mitral valve, and seizures. Client #1's ISP (Individual Support Plan) dated 12/17/12 indicated Client #1 had a COPD Management Plan dated 12/13/12 which indicated Client #1's has an order for continual use of oxygen.</p> <p>Record review indicated Client #1 had a nursing quarterly review dated 6/29/13 in which the nurse indicated "very concerned with [Client #1]'s gait. He depends on the walls to keep him up on his feet. I was told by staff that this was a good day also. I believe he needs to be evaluated by his PCP (primary care physician) and we need an order for a wheelchair at home and at workshop. Staff would need to walk him when able, but we need the wheelchair for back up to keep client safe."</p> <p>An interview with the QDDP (Qualified Development Disabilities Professional) on 10/17/13 at 3:17 PM stated Client #1's gait belt order was changed on 9/4/13 from a gait belt with 2 person assist to PRN (as needed) use because Client #1 "takes the gait belt off a lot." The QDDP indicated Client #1's fall risk plan had not been updated to reflect the Client #1's current PRN order for the gait belt. The QDDP indicated</p>						

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	<p>there was no follow up on the nurse quarterly dated 6/29/13 recommendations. The QDDP indicated Client #1 had no further doctor appointments after the nurse quarterly to clarify orders for the wheelchair and to assess the safety of his gait.</p> <p>During an interview on 11/1/13 at 1:45 PM, the facility nurse indicated she is not the staff responsible for setting up appointments. The facility nurse indicated she heard in July 2013 there was to be a follow up with his primary care physician but she never heard back whether it was complete or what the results were.</p> <p>9-3-6(a)</p>			

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W000455	<p>483.470(l)(1) INFECTION CONTROL</p> <p>There must be an active program for the prevention, control, and investigation of infection and communicable diseases.</p> <p>Based on observation and interview, the facility failed to ensure proper infection control procedures were implemented during the administration of medication for 2 of 5 clients observed during medication administration (Clients #4 and #5).</p> <p>Findings include:</p> <p>Group home observations were completed on 10/16/13 between 4:20 PM and 6:57 PM and on 10/17/13 from 6:46 AM until 8:17 AM. On 10/17/13 at 7:00 AM, DSP (direct support professional) #1 was observed administering medications. At 7:15 AM, DSP #1 assisted Client #4 in medication administration. DSP #1 assisted Client #4 in popping his pills from the bubble packs into a medication cup. DSP #1 assisted Client #4 in placing these medications into the cup: Digoxin 125 mg (milligrams), Osco 500 with Vitamin D, Oxybutynin 5 mg, Lisinopril 10 mg, Digoxin 125 mg, and Polyethylene Glycol. DSP #1 was observed to hand each pill to Client #4 with her bare hands for administration. Client #4 took each pill with water.</p> <p>On 10/17/13 at 7:25 AM, DSP #1 assisted Client #5 with medication administration. DSP #1 assisted Client #5 with popping each pill from the bubble pack and into a medication cup. DSP #1 assisted Client #5 in popping these medications into the cup: Aspirin 80 mg, Cetirizine 10mg, Omeprazole, Osco 500, and Naproxen 500 mg. DSP #1 handed each pill to Client #5 as he took them with water.</p>	W000455	455 - INFECTION CONTROL Peak Community Services through the IDT system will ensure that it provides a sanitary environment to avoid sources and transmissions of infections and that there is an active program for the prevention, control, and investigation of infection and communicable diseases. DSP # 1 has been in-serviced on the need to follow the infection control protocol in dispensing medications. This protocol prohibits the use of bare hands in dispensing medications. To monitor the corrective action Peak Community Services, Residential Coordinator, QMRP staff and the Residential Manager will monitor the use of proper sanitary procedures in their routine residence observations that are conducted at random times during the month. This monitoring will continue on a permanent basis. Systematically the need to maintain sanitary conditions while dispensing medications in the SGL residence will be addressed at SGL monthly staff meetings from 12. 01.13 to 05.01.14 Systematically all DSP's in the Peak Community Services SGL system have been in-serviced on the need to follow	12/01/2013			

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	<p>During an interview on 10/17/13 at 7:45 AM, DSP #1 indicated she agreed handing clients each pill using her bare hands was not proper infection control.</p> <p>On 11/1/13 at 1:45 PM during an interview, the facility LPN indicated it is not proper infection control procedures to hand clients their medications using bare hands.</p> <p>9-3-7(a)</p>		<p>the infection control protocol in dispensing medications. This protocol prohibits the use of bare hands in dispensing medications. Person Responsible:Amanda Clapp, Residential CoordinatorJan Adair, Residential ManagerSandra Beckett, QDDPCompletion Date: 12.01.13</p>		